Enhanced Benefit Services for Mental Health and Substance Abuse
Effective March 20, 2006

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Community Support – Adults (MH/SA)
Medicaid Billable Service

Service Definition and Required Components

Community Support consists of mental health and substance abuse rehabilitation services and supports necessary to assist the person in achieving and maintaining rehabilitative, sobriety, and recovery goals. The service is designed to meet the mental health/substance abuse treatment, financial, social, and other treatment support needs of the recipient. The service is also designed to assist the recipient in acquiring mental health/substance abuse recovery skills necessary to successfully address his/her educational, vocational, and housing needs. The Community Support Professional provides coordination of movement across levels of care, directly to the person and their family and coordinates discharge planning and community re-entry following hospitalization, residential services and other levels of care. The service includes providing "first responder" crisis response on a 24/7/365 basis to consumers experiencing a crisis. The service activities of Community Support consist of a variety of interventions: identification and intervention to address barriers that impede the development of skills necessary for independent functioning in the community; family psychoeducation development and revision of the recipient's Person Centered Plan; and one-on-one interventions with the community to develop interpersonal and community coping skills, including adaptation to home, school, and work environments; therapeutic mentoring; symptom monitoring; monitoring medications; and self management of symptoms. Community Support includes case management to arrange, link or integrate multiple services as well as assessment and reassessment of the recipient's need for services. Community Support workers also inform the recipient about benefits, community resources, and services; assist the recipient in accessing benefits and services; arrange for the recipient to receive benefits and services; and monitor the provision of services.

The Community Support worker must consult with identified providers, include their input into the Person Centered Planning process, inform all involved stakeholders, and monitor the status of the recipient in relationship to the treatment goals. The organization assumes the roles of advocate, broker, coordinator, and monitor of the service delivery system on behalf of the recipient. The Community Support Professional provides coordination of movement across levels of care, directly to the person and their family and coordinates discharge planning and community re-entry following hospitalization, residential services and other levels.

A service order for Community Support services must be completed by a physician, licensed psychologist, physician's assistant or nurse practitioner according to their scope of practice prior to or on the day that the services are to be provided.

Provider Requirements

Community Support services must be delivered by practitioners employed by a mental health/substance abuse provider organization that meet the provider qualification policies, procedures, and standards established by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH) and the requirements of 10A NCAC 27G These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrate that they meet these standards by being endorsed by the LME. Within three years of enrollment as a provider, the organization must have achieved national accreditation. The organization must be established as a legally recognized entity in the United States and qualified/registered to do business as a corporate entity in the State of North Carolina.

The Community Support provider organization is identified in the Person Centered Plan and is responsible for obtaining authorization from the LME for the Person Centered Plan. Community Support providers must have the ability to deliver services in various environments, such as homes, schools, jails*****, homeless shelters, street locations, etc.

***Note:** For all services, federal Medicaid regulations will deny Medicaid payment for services delivered to inmates of public correctional institutions or for patients in facilities with more than 16 beds that are classified as Institutions of Mental Diseases.

Organizations that provide Community Support services must provide "first responder" crisis response on a 24/7/365 basis to recipients who are receiving community support services.

Staffing Requirements

Persons who meet the requirements specified for Qualified Professional or Associated Professionals (AP) status according to 10A NCAC 27G.0104 and who have the knowledge, skills, and abilities required by the population and age to be served may deliver Community Support. Qualified Professionals (QP) are responsible for developing and coordinating the Person Centered Plan. APs and Paraprofessionals may deliver Community Support services to assist the consumer to develop critical daily living and coping skills.

All Associate Professionals and Paraprofessionals providing Community Support must be supervised by a QP. Supervision must be provided according to supervision requirements specified in 10A NCAC 27G.0204 and according to licensure or certification requirements of the appropriate discipline.

Associate Professionals and Paraprofessional level-providers who meet the requirements specified for Paraprofessional or AP status according to 10A NCAC 27G.0104 may deliver Community Support as follows: service coordination activities within the established Person-Centered Plan, referral linkage, skill building, supportive counseling, and input into the Person-Centered Plan modifications. When a Paraprofessional provides Community Support services, a QP is responsible for overseeing the development of the recipient's Person-Centered Plan.

A Certified Clinical Supervisor (CCS) and Certified Clinical Addiction Specialist (CCAS) may also deliver Community Support.

The following chart sets forth the activities that can be performed by a QP, CCS, CCAS, AP, or Paraprofessional. These activities reflect the appropriate scope of practice for these individuals.

Qualified Professional **Certified Clinical Supervisor** **Certified Clinical Addiction Specialist**	**Associate Professional** **Paraprofessional**
• Coordination and Oversight of Initial and Ongoing Assessment Activities • Initial Development and Ongoing Revision of PCP • Monitoring of Implementation of PCP • Additional Case Management functions of linking, arranging for services and referrals	• Various Skill Building Activities • Training of the caregiver • Daily and Community Living Skills • Socialization Skills • Adaptation Skills • Development of Leisure Time Interests/Activities • Symptom Monitoring and Management Skills • Therapeutic mentoring • Education substance abuse • Behavior and anger management

All staff providing community support to adults must complete a minimum of twenty (20) hours of training specific to the required components of the community support service definition including crisis response within the first 90 days of employment.

Service Type/Setting

Community Support is a direct and indirect periodic service where the Community Support worker provides direct intervention and also arranges, coordinates, and monitors services on behalf of the recipient. This service is provided in any location*. Community Support services may be provided to an individual or a group of individuals.

***Note:** For all services, federal Medicaid regulations will deny Medicaid payment for services delivered to inmates of public correctional institutions or for patients in facilities with more than 16 beds that are classified as Institutions of Mental Diseases.

Community Support services are provided in a range of community settings such as recipient's home, school, homeless shelters, libraries, etc. Community Support services can also be billed for individuals living in independent living or supervised living (low or moderate). Community Support also includes telephone time with the individual recipient and collateral contact with persons who assist the recipient in meeting his/her rehabilitation goals. Community Support activities include person-centered planning meetings and meetings for Person Centered Plan development.

Program Requirements

Caseload size for a Community Support qualified professional may not exceed 1:30 QP per thirty [30] clients). Community Support services may be provided to groups of individuals. When Community Support services are provided in a group, groups may not exceed eight (8) individuals.

Units are billed in fifteen (15) minute increments.

Program services are primarily delivered face-to-face with the recipient and in locations outside the agency's facility. The aggregate services that have been delivered by the agency will be assessed annually for each provider agency using the following quality assurance benchmarks:

- all individuals receiving Community Support must receive a minimum of two (2) contacts per month with one (1) contact occurring face-to-face with the recipient;
- a minimum of sixty percent (60%) or more of Community Support services that are delivered must be performed face-to-face with recipients; and
- a minimum of sixty percent (60%) or more of staff time must be spent working outside of the agency's facility, with or on behalf of the recipients.

Utilization Management

Authorization by the statewide vendor or the LME if approved by DHHS is required. The amount, duration, and frequency of services must be included in an individual's Person-Centered Plan and authorized on or before the day services are to be provided. Initial authorization for services must not exceed 30 days. Reauthorization will occur a minimum of ninety (90) days thereafter by the statewide vendor or LME and is to be documented in the Person-Centered Plan and service record. If it is a Medicaid covered service, utilization management will be done by the state vendor or the LME approved by DHHS and contracted with the Medicaid agency. If it is a non-covered Medicaid service or non-Medicaid client, then the utilization review will be done by the LME.

A maximum of thirty-two (32) units of Community Support services can be provided in a 24-hour period. No more than 112 units per week of services can be provided to an individual unless additional service is authorized based on medical necessity.

Entrance Criteria

The recipient is eligible for this service when:

A. there are two (2) identified needs in the appropriate documented life domains

AND

B. there is an Axis I or II diagnosis present, other than a sole diagnosis of Developmental Disability

AND/OR

C. ASAM (American Society for Addiction Medicine) criteria are met

AND

D. the recipient is experiencing difficulties in at least one of the following areas:

1. is at risk for institutionalization, or hospitalization or is placed outside the natural living environment.
2. is receiving or needs crisis intervention services
3. has unmet identified needs for services from multiple agencies
4. needs advocacy and service coordination to direct service provision from multiple agencies
5. DSS has substantiated abuse, neglect, or has established dependency as defined by DSS criteria
6. recipient exhibits intense, verbal and limited physical aggression due to symptoms associated with diagnosis that is sufficient to create functional problems in the home, community, school, job, etc.
7. functional problems that may result in the recipient's inability to access clinic-based services in a timely or helpful manner
8. is in active recovery from substance abuse/dependency and is in need of continuing relapse prevention support

Continued Stay Criteria

The desired outcome or level of functioning has not been restored, improved or sustained over the time frame outlined in the recipient's Person Centered Plan or the recipient continues to be at risk for relapse based on history or the tenuous nature of the functional gains or any one of the following apply:

A. Recipient has achieved initial Person Centered Plan goals but additional goals are indicated.

B. Recipient is making satisfactory progress toward meeting goals.

C. Recipient is making some progress, but the Person Centered Plan (specific interventions) needs to be modified so that greater gains, which are consistent with the recipient's premorbid level of functioning, are possible or can be achieved.

D. Recipient is not making progress; the Person Centered Plan must be modified to identify more effective interventions.

E. Recipient is regressing; the Person Centered Plan must be modified to identify more effective interventions.

AND

Utilization review must be conducted a minimum of ninety (90) days (after the initial thirty [30] day authorization review) and is in the recipient's chart.

Discharge Criteria

Recipient's level of functioning has improved with respect to the goals outlined in the Person Centered Plan, inclusive of a transition plan to step down, or no longer benefits from this service, or has the ability to function at this level of care and any of the following apply:

A. Recipient has achieved positive life outcomes that support stable and ongoing recovery.

B. Recipient is not making progress or is regressing and all realistic treatment options have been exhausted indicating a need for more intensive services.

C. Recipient/family no longer wishes to receive Community Support services.

D. Recipient has achieved one (1) year of abstinence from misuse of substances.

Note: Any denial, reduction, suspension or termination of service requires notification to the recipient and/or legal guardian about their appeal rights.

Expected Outcomes

This service includes interventions that address the functional problems associated with complex and/or complicated conditions of the identified population. These interventions are strength-based and focused on promoting recovery, symptom reduction, increased coping skills, and achievement of the highest level of functioning in the community. The focus of the interventions include: minimizing the negative effects of psychiatric symptoms or substance dependence that interfere with the recipient's daily living, financial management and personal development; developing strategies and supportive interventions for avoiding out-of-home placements for adults; supporting ongoing treatment; assisting recipients to increase social support skills that ameliorate life stresses resulting from the recipient's disability and coordinating rehabilitation services in the Person Centered Plan.

Documentation Requirements

Minimum standard is a daily full service note that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, describes the provider's interventions, includes the time spent performing the interventions, effectiveness of the intervention, the signature and credentials of the staff providing the service.

Service Exclusions/Limitations

An individual can receive Community Support services from only one Community Support provider organization at a time.

Community Support can be provided to individuals residing in all Adult mental health residential levels (i.e., Supervised Living Low or Moderate and Group Living Low, Moderate or High).

Group Community Support cannot be billed on the same day as Psychosocial Rehabilitation Services.

Community Support cannot be provided during the same authorization period with the following services except as specified below: Partial Hospitalization, SACOT, SAIOP or SA Non-Medical Community Residential Treatment.

Service Limitations: Community Support services can be billed for a maximum of eight (8) units per month in accordance with the PCP for individuals, who are receiving a service listed above, to facilitate admission/transition to the service, to provide coordination during the provision of the service and /or to transition from the service based on the Person Centered Plan.

Note: For recipients under the age of 21, additional products, services, or procedures may be requested even if they do not appear in the N.C. State Plan or when coverage is limited to those over 21 years of age. Service limitations on scope, amount, or frequency described in the coverage policy may not apply if the product, service, or procedure is medically necessary

Community Support – Children/Adolescents (MH/SA)
Medicaid Billable Service

Service Definition and Required Components

Community Support services are services and supports necessary to assist the youth ages 3 to 17 years of age or younger (20 years old or younger for children enrolled in Medicaid) and their caregivers in achieving, rehabilitative, and recovery goals. Community Support services are psychoeducational and supportive in nature and intended to meet the mental health or substance abuse needs of children and adolescents with significant functional deficits or who, because of negative environmental, medical or biological factors, are at risk of developing or increasing the magnitude of such functional deficits. Included among this latter group are those at risk for atypical development, substance abuse, or serious emotional disturbance (SED) that could result in an inability to live successfully in the community without services and guidance.

The service activities of Community Support consist of a variety of interventions: education and training of caregivers and others who have a legitimate role in addressing the needs identified in the Person Centered Plan; preventive, and therapeutic interventions designed for direct individual activities; assist with skill enhancement or acquisition, and support ongoing treatment and functional gains; development of the consumer's Person Center Plan, and one-on-one interventions with the consumer to develop interpersonal and community relational skills, including adaptation to home, school, work and other natural environments; therapeutic mentoring; and symptom monitoring and self-management of symptoms. Community Support includes case management to arrange, link or integrate multiple services as well as assessment and reassessment of the recipient's need for services. Community Support workers also inform the recipient about benefits, community resources, and services; assist the recipient in accessing benefits and services; arrange for the recipient to receive benefits and services; and monitor the provision of services. The Community Support Professional provides coordination of movement across levels of care, directly to the person and their family and coordinates discharge planning and community re-entry following hospitalization, residential services and other levels of care. The service includes providing "first responder" crisis response on a 24/7/365 basis to consumers experiencing a crisis.

A service order for Community Support services must be completed by a physician, licensed psychologist, physician's assistant or nurse practitioner according to their scope of practice prior to or on the day that the services are to be provided.

Provider Requirements

Community Support services must be delivered by practitioners employed by a mental health/substance abuse provider organization that meet the provider qualification policies, procedures, and standards established by DMH and the requirements of 10A NCAC 27G These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrate that they meet these standards by being endorsed by the LME. Within three years of enrollment as a provider, the organization must have achieved national accreditation. The organization must be established as a legally recognized entity in the United States and qualified/registered to do business as a corporate entity in the State of North Carolina.

Community Support providers must have the ability to deliver services in various environments, such as homes, schools, detention centers and jails (state funds only), homeless shelters, street locations, etc.

Note: For all services, federal Medicaid regulations will deny Medicaid payment for services delivered to inmates of public correctional institutions.

Organizations that provide Community Support services must also provide 24/7/365 crisis response to consumers and their families who are receiving community support services.

Staffing Requirements

Persons who meet the requirements specified for QP or AP status according to 10A NCAC 27G.0104 and who have the knowledge, skills, and abilities required by the population and age to be served may deliver Community Support within the requirements of the staff definition specified in the above rule. Supervision is provided according to supervision requirements specified in 10A NCAC 27G.0203 and according to licensure or certification requirements of the appropriate discipline.

Associate Professionals and Paraprofessional level providers who meet the requirements specified for Paraprofessional or AP status according to 10A NCAC 27G.0204 and who have the knowledge, skills, and abilities required by the population and age to be served may deliver Community Support services as follows: service coordination activities within the established Person-Centered Plan, referral linkage, skill building, supportive counseling, and input into the Person-Centered Plan modifications. When an AP or Paraprofessional provides Community Support services, these services must be under the supervision of a QP. Supervision of APs or Paraprofessionals is also to be carried out according to 10A NCAC 27G.0204.

The following chart sets forth the activities that can be performed by a QP, CCS, CCAS, AP, and Paraprofessional. These activities reflect the appropriate scope of practice for these individuals.

Qualified Professional **Certified Clinical Supervisor** **Certified Clinical Addiction Specialist**	**Associate Professional** **Paraprofessional**
• Coordination and Oversight of Initial and Ongoing Assessment Activities • Initial Development and Ongoing Revision of PCP • Monitoring of Implementation of PCP • Other case management functions of linking and referring	Various Skill Building Activities • Training of caregiver • Daily and Community Living Skills • Socialization Skills • Adaptation Skills • Symptom Monitoring and Management Skills • Education substance abuse • Therapeutic mentoring • Behavior and anger management techniques

All staff must complete a minimum of twenty (20) hours of training specific to the required components of the community support service definition including crisis response within the first 90 days of employment.

Service Type/Setting

Community Support is a direct and indirect periodic service where the Community Support worker provides direct intervention and also arranges, coordinates, and monitors services on behalf of the recipient. This service is provided in any location*. Community Support services may be provided to an individual or a group of individuals.

Community Support also includes telephone time with the individual recipient and collateral contact with persons who assist the recipient in meeting his/her rehabilitation goals. Community Support activities include person-centered planning meetings and meetings for Person Centered Plan development.

***Note:** For all services, federal Medicaid regulations will deny Medicaid payment for services delivered to inmates of public correctional institutions (detention centers/ youth correctional facilities, jails).

Program Requirements

Caseload size for a Community Support qualified professional may not exceed 1 to 15 Community Support services may be provided to groups of individuals. When Community Support services are provided in a group, groups may not exceed eight individuals.

Units are billed in fifteen (15) minute increments.

Program services are primarily delivered face-to-face with the recipient and in locations outside the agency's facility. Annually the aggregate services that have been delivered by the agency will be assessed for each provider agency using the following quality assurance benchmarks:

- all youth receiving Community Support must receive a minimum of two (2) contacts per month with one (1) contact occurring face-to-face with the recipient;
- a minimum of sixty percent (60%) or more of Community Support services that are delivered must be performed face-to-face with recipients; and
- a minimum of sixty percent (60%) or more of staff time must be spent working outside of the agency's facility, with or on behalf of consumers.

Utilization Management

Authorization by the statewide vendor or the LME if approved by DHHS is required. The amount, duration, and frequency of the services must be included in an individual's Person Centered Plan, and authorized prior to or on the day services are to be provided. Initial authorization for services may not exceed thirty (30) days. Reauthorization will occur a minimum of (90) days thereafter by the statewide vendor or LME and is to be documented in the Person Centered Plan and service record. If it is a Medicaid covered service, utilization management will be done by the state vendor or the DHHS approved LME contracted with the Medicaid agency. If it is a non-covered Medicaid service or non-Medicaid client, then the utilization review will be done by the LME.

A maximum of thirty-two (32) units of Community Support services can be provided in a 24-hour period unless specific authorization for exceeding this limit is approved. No more than112 units per week of Community Support services can be provided to an individual unless specific authorization by the LME/state vender to exceed this limit is approved.

Entrance Criteria

The recipient is eligible for this service when:

A. there are two (2) identified needs in the appropriate documented life domains

AND

B. there is an Axis I or II diagnosis present, other than a diagnosis of primary Developmental Disability

AND/OR

C. NC Modified ASAM (American Society for Addiction Medicine),

AND

D. the recipient is experiencing difficulties in at least one of the following areas:

1. is at risk for institutionalization or hospitalization or is placed outside the natural living environment
2. is receiving or needs crisis intervention services or Intensive In-Home services
3. has unmet identified needs from multiple agencies
4. needs advocacy and service coordination to direct service provisions from multiple agencies
5. DSS has substantiated abuse, neglect, or has established dependency
6. presenting with intense, verbal, and limited physical aggression due to symptoms associated with diagnosis, which aggression is sufficient to create functional problems in the home, community, school, job, etc.
7. functional problems which may result in the recipient's inability to access clinic-based services in a timely or helpful manner
8. is in active recovery from substance abuse/dependency and is in need of continuing relapse prevention support

Continued Stay Criteria

The desired outcome or level of functioning has not been restored, improved or sustained over the time frame outlined in the recipient's Person Centered Plan; or the recipient continues to be at risk for relapse based on history or the tenuous nature of the functional gains; or any one of the following apply:

A. Recipient has achieved initial Person Centered Plan goals and additional goals are indicated.

B. Recipient is making satisfactory progress toward meeting goals.

C. Recipient is making some progress, but the Person Centered Plan (specific interventions) need to be modified so that greater gains, which are consistent with the recipient's premorbid level of functioning, are possible or can be achieved.

D. Recipient is not making progress; the Person Centered Plan must be modified to identify more effective interventions.

E. Recipient is regressing; the Person Centered Plan must be modified to identify more effective interventions.

AND

Utilization review must be conducted a minimum of every ninety (90) days (after the initial thirty [30] day authorization) and is so documented in the Person-Centered Plan and service record.

Discharge Criteria

Recipient's level of functioning has improved with respect to the goals outlined in the Person Centered Plan, inclusive of a transition plan to step down; or no longer benefits from this service, or has the ability to function at this level of care; and any of the following apply:

A. Recipient has achieved goals and is no longer eligible for Community Support services.

B. Recipient is not making progress, or is regressing and all realistic treatment options have been exhausted indicating a need for more intensive services.

C. Recipient/family no longer wants Community Support services.

D. Recipient has achieved one (1) year of abstinence from substances.

Note: Any denial, reduction, suspension or termination of service requires notification to the recipient and/or legal guardian about their appeal rights.

Expected Outcomes

This service includes interventions that address the functional problems associated with complex and/or complicated conditions of the identified population. These interventions are strength-based and focused on promoting symptom stability, increased coping skills, and achievement of the highest level of functioning in the community. For substance abusers, the expected outcomes include the achievement of abstinence from substances. The focus of the interventions include: minimizing the negative effects of psychiatric and substance abuse symptoms that interfere with the recipient's daily living; improving and sustaining developmentally appropriate functioning in specified domains; financial management and personal development; developing strategies and supportive interventions for avoiding out-of-home placements; supporting ongoing treatment assisting recipients to increase social support skills that ameliorate life stresses resulting from the recipient's disability and coordinating rehabilitation services in the Person Centered Plan.

Documentation Requirements

Minimum standard is a daily full service note that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, describes the provider's interventions, includes the time spent performing the interventions, effectiveness of the intervention, and the signature of the staff providing the service.

Service Exclusions/Limitations

An individual can receive Community Support services from only one (1) Community Support provider organization at a time.

Community Support services can not be billed for individuals who are receiving Intensive In -Home service, Multisystemic Therapy, SAIOP, Day Treatment, Level II-IV Child Residential or Substance Abuse Residential services except as referenced below

Service Limitation: Community support services can be billed for a maximum of 8 units per month in accordance with the person centered plan for individuals who are receiving one of the services listed above for the purpose of facilitating transition to the service , admission to the service, meeting with the person as soon as possible upon admission, providing coordination during the provision of service, ensuring that the service provider works directly with the CS Professional and discharge planning.

Note: For recipients under the age of 21, additional products, services, or procedures may be requested even if they do not appear in the N.C. State Plan or when coverage is limited to those over 21 years of age. Service limitations on scope, amount, or frequency described in the coverage policy may not apply if the product, service, or procedure is medically necessary.

Mobile Crisis Management (MH/DD/SA)
Medicaid Billable Service

Service Definition and Required Components

Mobile Crisis Management involves all support, services and treatments necessary to provide integrated crisis response, crisis stabilization interventions, and crisis prevention activities. Mobile Crisis Management services are available at all times, 24/7/365. Crisis response provides an immediate evaluation, triage and access to acute mental health, developmental disabilities, and/or substance abuse services, treatment, and supports to effect symptom reduction, harm reduction, and/or to safely transition persons in acute crises to appropriate crisis stabilization and detoxification supports/services. These services include immediate telephonic response to assess the crisis and determine the risk, mental status, medical stability, and appropriate response.

Mobile Crisis Management also includes crisis prevention and supports that are designed to reduce the incidence of recurring crises. These supports and services should be specified in a recipient's Crisis Plan, which is a component of all Person Centered Plans.

Provider Requirements

Mobile Crisis Management services must be delivered by a team of practitioners employed by a mental health/substance abuse/developmental disability provider organization that meets the provider qualification policies and procedures established by DMH and the requirements of 10A NCAC 27I.0208 (Endorsement of Providers). These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrate that they meet these standards by being endorsed by the LME. Within three years of enrollment as a provider, the organization must have achieved national accreditation. The organization must be established as a legally recognized entity in the United States and qualified/registered to do business as a corporate entity in the State of North Carolina.

Staffing Requirements

Mobile Crisis Management services must be provided by a team of individuals that includes a QP according to 10A NCAC 27G.0104 and who must either be a nurse, clinical social worker or psychologist as defined in this administrative code. One of the team members must be a CCAS, CCS or a Certified Substance Abuse Counselor (CSAC). Each organization providing crisis management must have 24/7/365 access to a board certified or eligible psychiatrist. The psychiatrist **must** be available for face to face or phone consultation to crisis staff. A QP or AP with experience in Developmental Disabilities must be available to the team as well. Paraprofessionals with competency in crisis management may also be members of the crisis management team when supervised by the QP. A supervising professional must be available for consultation when a Paraprofessional is providing services.

All staff providing crisis management services must demonstrate competencies in crisis response and crisis prevention. At a minimum, these staff must have:

- a minimum of one (1) year's experience in providing crisis management services in the following settings: assertive outreach, assertive community treatment, emergency department or other service providing 24/7 response in emergent or urgent situations

AND

- twenty (20) hours of training in appropriate crisis intervention strategies within the first 90 days of employment

Professional staff must have appropriate licenses, certification, training and experience and non-licensed staff must have appropriate training and experience.

Service Type/Setting

Mobile Crisis Management is a direct and periodic service that is available at all times, 24/7/365. It is a "second level" service, in that other services should be billed before Crisis Management, as appropriate and if there is a choice. For example, if the recipient's outpatient clinician stabilized his/her crisis, the outpatient billing code should be used, not crisis management. If a Community Support worker responds and stabilizes his/her crisis, the Community Support billing code should be used.

Units will be billed in fifteen (15) minute increments.

Mobile Crisis Management services are primarily delivered face-to-face with the consumer and in locations outside the agency's facility. Annually the aggregate services that have been delivered by the agency will be assessed for each provider agency using the following quality assurance benchmarks:

Team providing this service must provide at least eighty percent (80%) of their units on a face-to-face with recipients of this service.

If a face-to-face assessment is required, this assessment must be delivered in the least restrictive environment and provided in or as close as possible to a person's home, in the individual's natural setting, school, work, local emergency room, etc. This response must be mobile. The result of this assessment should identify the appropriate crisis stabilization intervention.

Note: For all services, federal Medicaid regulations will deny Medicaid payment for services delivered to inmates of public correctional institutions or for patients in facilities with more than 16 beds that are classified as Institutions of Mental Diseases.

Program Requirements

Mobile Crisis Management services should be delivered in the least restrictive environment and provided in or as close as possible to a person's home.

Mobile Crisis Management services must be capable of addressing all psychiatric, substance abuse, and developmental disability crises for all ages to help restore (at a minimum) an individual to his/her previous level of functioning.

Mobile Crisis Management services may be delivered by one (1) or more individual practitioners on the team.

For recipients new to the public system, Mobile Crisis Management must develop a Crisis Plan before discharge. This Crisis Plan should be provided to the individual, caregivers (if appropriate), and any agencies that may provide ongoing treatment and supports after the crisis has been stabilized. For recipients who are already receiving services, Mobile Crisis Management should recommend revisions to existing crisis plan components in Person Centered Plans, as appropriate.

Utilization Management

There is no prior authorization for the first 32 units of crisis services per episode. The maximum length of service is 24 hours per episode. Additional authorization must occur after 32 units of services have been rendered. For individuals enrolled with the LME, the crisis management provider must contact the LME to determine if the individual is enrolled with a provider that should and can provide or be involved with the response. Mobile Crisis Management should be used to divert individuals from inpatient psychiatric and detoxification services. These services are not used as "step down" services from inpatient hospitalization.

If it is a Medicaid covered service, utilization management will be done by the state vendor or the DHHS approved LME contracted with the Medicaid agency. If it is a non-covered Medicaid service or non-Medicaid client, then the utilization review will be done by the LME.

The maximum length of service is 24 hours per episode.

Entrance Criteria

The recipient is eligible for this service when:

A. the person and/or family are experiencing an acute, immediate crisis as determined by a crisis rating scale specified by DMH

AND

B. the person and/or family has insufficient or severely limited resources or skills necessary to cope with the immediate crisis

OR

C. the person and/or family members evidences impairment of judgment and/or impulse control and/or cognitive/perceptual disabilities

OR

D. the person is intoxicated or in withdrawal and in need of substance abuse treatment and unable to access services without immediate assistance

Priority should be given to individuals with a history of multiple crisis episodes and/or who are at substantial risk of future crises.

Continued Stay Criteria

The recipient's crisis has not been resolved or their crisis situation has not been stabilized, which may include placement in a facility-based crisis unit or other appropriate residential placement.

Discharge Criteria

Recipient's crisis has been stabilized and his/her need for ongoing treatment/supports has been assessed. If the recipient has continuing treatment/support needs, a linkage to ongoing treatment or supports has been made.

Note: Any denial, reduction, suspension or termination of service requires notification to the recipient and/or legal guardian about their appeal rights.

Expected Outcomes

This service includes a broad array of crisis prevention and intervention strategies which assist the recipient in managing, stabilizing or minimizing clinical crisis or situations. This service is designed to rapidly assess crisis situations and a recipient's clinical condition, to triage the severity of the crisis, and to provide immediate, focused crisis intervention services which are mobilized based on the type and severity of crisis.

Documentation Requirements

Minimum standard is a daily full service note that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, describes the provider's interventions, includes the time spent performing the interventions, effectiveness of the intervention, and the signature of the staff providing the service. Treatment logs or preprinted check sheets will not be sufficient to provide the necessary documentation. For recipients new to the public system, Mobile Crisis Management must develop a crisis plan before discharge.

Service Exclusions

Assertive Community Treatment, Intensive In-Home Services, Multisystemic Therapy, Medical Community Substance Abuse Residential Treatment, Non-Medical Community Substance Abuse Residential Treatment, Detoxification Services, Inpatient Substance Abuse Treatment, Inpatient Psychiatric Treatment, and Psychiatric Residential Treatment Facility except for the day of admission. Mobile Crisis Management services may be provided to an individual who receives inpatient psychiatric services on the same day of service.

Note: For recipients under the age of 21, additional products, services, or procedures may be requested even if they do not appear in the N.C. State Plan or when coverage is limited to those over 21 years of age. Service limitations on scope, amount, or frequency described in the coverage policy may not apply if the product, service, or procedure is medically necessary.

Diagnostic/Assessment (MH/DD/SA)
Medicaid Billable Service

Service Definition and Required Components

A Diagnostic/Assessment is an intensive clinical and functional face to face evaluation of a recipient's mental health, developmental disability, or substance abuse condition that results in the issuance of a Diagnostic/Assessment report with a recommendation regarding whether the recipient meets target population criteria, and includes an order for Enhanced Benefit services that provides the basis for the development of an initial Person Centered Plan. For substance abuse-focused Diagnostic/Assessment, the designated Diagnostic Tool specified by DMH (e.g., SUDDS IV, ASI, SASSI) for specific substance abuse target populations (i.e., Work First, DWI, etc.) must be used. In addition, any elements included in this service definition that are not covered by the tool must be completed.

The Diagnostic/Assessment must include the following elements:

A. a chronological general health and behavioral health history (includes both mental health and substance abuse) of the recipient's symptoms, treatment, treatment response and attitudes about treatment over time, emphasizing factors that have contributed to or inhibited previous recovery efforts;
B. biological, psychological, familial, social, developmental and environmental dimensions and identified strengths and weaknesses in each area;
C. a description of the presenting problems, including source of distress, precipitating events, associated problems or symptoms, recent progressions; and current medications
D. a strengths/problem summary which addresses risk of harm, functional status, co-morbidity, recovery environment, and treatment and recovery history;
E. diagnoses on all five (5) axes of DSM-IV;
F. evidence of an interdisciplinary team progress note that documents the team's review and discussion of the assessment;
G. a recommendation regarding target population eligibility; and
H. evidence of recipient participation including families, or when applicable, guardians or other caregivers

This assessment will be signed and dated by the MD, DO, PA, NP, licensed psychologist and will serve as the ~~i~~nitial order for services included in the PCP. Upon completion, the PCP will be sent to the LME for administrative review and authorization of services under the purview of the LME.

For additional services added after the development of the initial PCP, the order requirement for each service is included in the service definition.

Provider Requirements

Diagnostic/Assessments must be conducted by practitioners employed by a mental health/substance abuse/developmental disability provider meet the provider qualification policies, procedures, and standards established by DMH and the requirements of 10A NCAC 27G These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrate that they meet these standards by being endorsed by the LME. Within three years of enrollment as a provider, the organization must have achieved national accreditation. The organization must be established as a legally recognized entity in the United States and qualified/registered to do business as a corporate entity in the State of North Carolina.

Staffing Requirements

The Diagnostic/Assessment team must include at least two (2) QPs, according to 10A NCAC 27G.0104, both of whom are licensed or certified clinicians; one (1) of the team members must be a qualified practitioner whose professional licensure or certification authorizes the practitioner to diagnose mental illnesses and/or addictive disorders. One of which must be an MD, DO, Nurse Practitioner, Physician Assistant, or licensed psychologists. For substance abuse-focused Diagnostic/Assessment, the team must include a CCS or CCAS. For developmental disabilities, the team must include a Master's level qualified professional with at least two years experience with the developmentally disabled.

Service Type/Setting

Diagnostic/Assessment is a direct periodic service that can be provided in any location.*

***Note:** For Medicaid recipients this service cannot be provided in an IMD (for adults) or in a public institution, (jail, detention center,)

Program Requirements

An initial Diagnostic/Assessment shall be performed by a Diagnostic/Assessment team for each recipient being considered for receipt of services in the mental health, developmental disabilities, and/or substance abuse Enhanced Benefit package.

Utilization Management

A recipient may receive one Diagnostic/Assessment per year. An assessment equals one (1) event. For individuals eligible for Enhanced Benefit services, referral by the LME for Diagnostic/Assessment is required. Additional events require prior authorization from the statewide vendor or LME.

If it is a Medicaid covered service, utilization management will be done by the state vendor or the DHHS approved LME contracted with the Medicaid agency. If it is a non-covered Medicaid service or non-Medicaid client, then the utilization review will be done by the LME.

Entrance Criteria

The recipient is eligible for this service when:

A. there is a known or suspected mental health, substance abuse diagnosis, or developmental disability diagnosis

OR

B. initial screening/triage information indicates a need for additional mental health/substance abuse/developmental disabilities treatment/supports.

Continued Stay Criteria

Not applicable.

Discharge Criteria

Not applicable.

Note: Any denial, reduction, suspension or termination of service requires notification to the recipient and/or legal guardian about their appeal rights.

Expected Outcomes

A Diagnostic/Assessment determines whether the recipient is appropriate for and can benefit from mental health, developmental disabilities, and/or substance abuse services based on the recipient's diagnosis, presenting problems, and treatment/recovery goals. It also evaluates the recipient's level of readiness and motivation to engage in treatment. Results from a Diagnostic/Assessment include an interpretation of the assessment information, appropriate case formulation and an order for immediate needs and the development of Person Centered Plan. For substance abusers, a Diagnostic/Assessment recommends a level of placement using N.C. Modified A/ASAM criteria. This assessment will include signing the order for the initial PCP. That order will constitute the order for the services in the PCP.

Documentation Requirements

The Diagnostic/Assessment must include the following elements:

A. a chronological general health and behavioral health history (includes both mental health and substance abuse) of the recipient's symptoms, treatment, treatment response and attitudes about treatment over time, emphasizing factors that

B. have contributed to or inhibited previous recovery efforts; biological, psychological, familial, social, developmental and environmental dimensions and identified strengths and weaknesses in each area;

C. a description of the presenting problems, including source of distress, precipitating events, associated problems or symptoms, recent progressions, and current medications

D. strengths/problem summary which addresses risk of harm, functional status, co-morbidity, recovery environment, and treatment and recovery history;

E. diagnoses on all five (5) axes of DSM-IV;

F. evidence of an interdisciplinary team progress note that documents the team's review and discussion of the assessment;

G. a recommendation regarding target population eligibility; and

H. evidence of recipient participation including families, or when applicable, guardians or other caregivers.

Service Exclusions/Limitations

A recipient may receive one (1) Diagnostic/Assessment per year. Any additional Diagnostic/Assessment within a one (1) year period must be authorized by the DHHS approved LME or the state wide vendor prior to the delivery of the service. Diagnostic/Assessment shall not be billed on the same day as Assertive Community Treatment, Intensive In-Home, Multisystemic Therapy or Community Support Team. If psychological testing or specialized assessments are indicated, they are billed separately using CPT codes that have been approved by psychological, .developmental or neuropsychological testing.

Note: For recipients under the age of 21, additional products, services, or procedures may be requested even if they do not appear in the N.C. State Plan or when coverage is limited to those over 21 years of age. Service limitations on scope, amount, or frequency described in the coverage policy may not apply if the product, service, or procedure is medically necessary.

Intensive In-Home Services
Medicaid Billable Service

Service Definition and Required Components

This is a time-limited intensive family preservation intervention intended to stabilize the living arrangement, promote reunification or prevent the utilization of out-of-home therapeutic resources (i.e., psychiatric hospital, therapeutic foster care, residential treatment facility) for the identified youth through the age of 20. These services are delivered primarily to children in their family's home with a family focus to:

1. Defuse the current crisis, evaluate its nature, and intervene to reduce the likelihood of a recurrence;
2. Ensure linkage to needed community services and resources;
3. Provide self help and living skills training for youth;
4. Provide parenting skills training to help the family build skills for coping with the youth's disorder;
5. Monitor and manage the presenting psychiatric and/or addiction symptoms; and
6. Work with caregivers in the implementation of home-based behavioral supports. Services may include crisis management, intensive case management, individual and/or family therapy, substance abuse intervention, skills training, and other rehabilitative supports to prevent the need for an out-of-home, more restrictive services.

This intervention uses a team approach designed to address the identified needs of children and adolescents who are transitioning from out of home placements or are at risk of out-of-home placement and need intensive interventions to remain stable in the community. This population has access to a variety of interventions twenty four (24) hours a day, seven (7) days per week by staff that will maintain contact and intervene as one (1) organizational unit.

Team services are individually designed for each family, in full partnership with the family, to minimize intrusion, and maximize independence. Services are generally more intensive at the beginning of treatment and decrease over time as the youth and family's coping skills develop.

The team services are structured and delivered face-to-face to provide support and guidance in all areas of functional domains: adaptive, communication, psychosocial, problem solving, behavior management, etc. This service is **not** delivered in a group setting.

A service order for Intensive In-Home services must be completed by a physician, licensed psychologist, physician's assistant or nurse practitioner according to their scope of practice prior to or on the day that the services are to be provided.

Provider Requirements

Intensive In-Home services must be delivered by practitioners employed by a mental health/substance abuse provider organization that meets the provider qualification policies, procedures, and standards established by DMH and the requirements of 10A NCAC 27G These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrate that they meet these standards by being endorsed by the LME. Within three years of enrollment as a provider, the organization must have achieved national accreditation. The organization must be established as a legally recognized entity in the United States and qualified/registered to do business as a corporate entity in the State of North Carolina.

Intensive In-Home Service providers must have the ability to deliver services in various environments, such as homes, schools, detention centers and jails (state funds only), homeless shelters, street locations, etc.

Organizations that provide Intensive In-Home Services must provide "first responder" crisis response on a 24/7/365 basis to recipients who are receiving this service.

Staffing Requirements

This service model includes both a licensed professional and a minimum of two (2) staff who are APs or provisional licensed and who have the knowledge, skills, and abilities required by the population and age to be served. The team leader must be a licensed professional and is responsible for coordinating the initial assessment and developing the youth's Person Centered Plan (PCP). The service model requires that in-home staff provide 24 hour coverage, 7 days per week. The licensed professional is also responsible for providing or coordinating (with another licensed professional) treatment for the youth or other family members. All treatment must be directed toward the eligible recipient of in-home services. Team to family ratio shall not exceed one to eight (1 to 8) for each three-person team. Intensive In-Home Services focused on substance abuse intervention must include a CCS, CCAS, or CSAC on the team.

Persons who meet the requirements specified for qualified professional or AP status according to 10A NCAC 27G.0104 and who have the knowledge, skills, and abilities required by the population and age to be served may deliver Intensive In-Home Services within the requirements of the staff definition specified in the above rule. Supervision is provided according to supervision requirements specified in 10A NCAC 27G.0104 and according to licensure and certification requirements of the appropriate discipline.

All staff providing Intensive In-Home Services to children and families must have a minimum of one (1) year documented experience with this population. In addition, all staff must complete the intensive in-home services training within the first 90 days of employment.

Service Type/Setting

Intensive In-Home services are direct and indirect periodic services where the team provides direct intervention and also arranges, coordinates, and monitors services on behalf of the recipient. This service is provided in any location. Intensive In-Home services are primarily provided in a range of community settings such as recipient's home, school, homeless shelters, libraries, etc. Intensive In-Home services also include telephone time with the individual recipient and collateral contact with persons who assist the recipient in meeting their goals specified in their Person Centered Plan.

Note: For all services, federal Medicaid regulations will deny Medicaid payment for services delivered to inmates of public correctional institutions, jails, or detention centers, or for patients in facilities with more than 16 beds that are classified as Institutions of Mental Diseases.

Clinical Requirements

For Intensive In-Home recipients, a minimum of twelve (12) contacts must occur within the first month. One contact will equal all visits occurring in a 24 (twenty-four) hour period of time starting at 7a.m. For the second and third months of Intensive In-Home services, an average of six (6) contacts per month must occur. It is the expectation that service frequency will be titrated over the last two (2) months.

Units will be billed on a per diem basis with a minimum of 2 hours per day

Services are primarily delivered face-to-face with the consumer and/or family and in locations outside the agency's facility. The aggregate services that have been delivered by the agency will be assessed annually for each provider agency using the following quality assurance benchmarks:

- A minimum of sixty percent (60%) of the contacts occur face-to-face with the youth and/or family. The remaining units may either be phone or collateral contacts; and
- A minimum of sixty percent (60%) or more of staff time must be spent working outside of the agency's facility, with or on behalf of the recipients.

Utilization Management

Authorization by the statewide vendor or the LME is required. The amount, duration, and frequency of the service must be included in a recipient's Person-Centered Plan. Initial authorization for services may not exceed thirty (30) days. Reauthorization will occur within a minimum of sixty (60) days ~~of~~ thereafter and is so documented in the Person Centered Plan and service record.

If it is a Medicaid covered service, utilization management will be done by the state vendor or the DHHS approved LME contracted with the Medicaid agency. If it is a non-covered Medicaid service or non-Medicaid client, then the utilization review will be done by the LME.

Entrance Criteria

A recipient is eligible for this service when:

A. There is an Axis I or II diagnosis present, other than a sole diagnosis of Developmental Disability.

AND

B. Treatment in a less intensive service (e.g., community support) was attempted or evaluated during the assessment but was found to be inappropriate or not effective.

AND

C. The youth and/or family have insufficient or severely limited resources or skills necessary to cope with an immediate crisis.

AND

D. The youth and/or family issues are unmanageable in school based or behavioral program settings and require intensive coordinated clinical and positive behavioral interventions.

AND

E. The youth is at risk of out-of-home placement or is currently in an out–of-home placement and reunification is imminent.

Continued Stay Criteria

The desired outcome or level of functioning has not been restored, improved or sustained over the time frame outlined in the youth's Person Centered Plan or the youth continues to be at risk for out-of-home placement:

A. Recipient has achieved initial Person Centered Plan goals and additional goals are indicated.

AND

B. Recipient is making satisfactory progress toward meeting goals.

AND

C. Recipient is making some progress, but the Person Centered Plan (specific interventions) needs to be modified so that greater gains, which are consistent with the recipient's premorbid level of functioning, are possible or can be achieved.

OR

D. Recipient is not making progress; the Person Centered Plan must be modified to identify more effective interventions.

OR

E. Recipient is regressing; the Person Centered Plan must be modified to identify more effective interventions.

Discharge Criteria

Service recipient's level of functioning has improved with respect to the goals outlined in the Person Centered Plan, inclusive of a transition plan to step down, or no longer benefits, or has the ability to function at this level of care and any of the following apply:

A. Recipient has achieved goals; discharge to a lower level of care is indicated, or recipient has entered a Substance Abuse Intensive Out-Patient Program.
B. The youth and families/caregivers have skills and resources needed to step down to a less intensive service.
C. There is a significant reduction in the youth's problem behavior and/or increase in pro-social behaviors.
D. The youth's or parent/guardian requests discharge (and is not imminently dangerous to self or others).
E. An adequate continuing care plan has been established.
F. The youth requires a higher level of care (i.e., inpatient hospitalization or PRTF).

Note: Any denial, reduction, suspension or termination of service requires notification to the recipient and/or legal guardian about their appeal rights.

Documentation Requirements

Minimum standard is a daily note for services provided that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, describes the provider's interventions, the time spent performing the intervention, the effectiveness of interventions and the signature of the staff providing the service.

Expected Outcomes

The individual's living arrangement has been stabilized, crisis needs have been resolved, linkage has been made with needed community service/resources; youth has gained living skills; parenting skills have been increased; need for out of home placements has been reduced/eliminated

Service Exclusions/Limitations

An individual can receive Intensive In-Home Services from only one Intensive In-Home provider organization at a time.

Intensive in-home services cannot be provided during the same authorization period with the following services except as specified below: Community Support, Multisystemic Therapy, Day Treatment, Hourly Respite, Individual, group or family therapy, SAIOP, or living in a Level II-IV child residential or substance abuse residential facility

Service Limitation: CS can be billed for a maximum of 8 units per month in accordance with the person centered plan for individuals who are receiving intensive in-home services for the purpose of facilitating transition to the service, admission to the service, meeting with the person as soon as possible upon admission, providing coordination during the provision of service, ensuring that the service provider works directly with the CS professional and discharge planning.

Note: For recipients under the age of 21, additional products, services, or procedures may be requested even if they do not appear in the N.C. State Plan or when coverage is limited to those over 21 years of age. Service limitations on scope, amount, or frequency described in the coverage policy may not apply if the product, service, or procedure is medically necessary.

Multisystemic Therapy (MST)
Medicaid Billable Service

Service Definition and Required Components

Multisystemic Therapy (MST) is a program designed for youth generally between the ages 7 through 17 who have antisocial, aggressive/violent behaviors, are at risk of out-of-home placement due to delinquency and/or; adjudicated youth returning from out-of-home placement and/or; chronic or violent juvenile offenders, and/or youth with serious emotional disturbances or abusing substances and their families. MST provides an intensive model of treatment based on empirical data and evidence-based interventions that target specific behaviors with individualized behavioral interventions. The purpose of this program is to keep youth in the home by delivering an intensive therapy to the family within the home. Services are provided through a team approach to youth and their families. Services include: an initial assessment to identify the focus of the MST intervention; individual therapeutic interventions with the youth and family; peer intervention; case management; and crisis stabilization. Specialized therapeutic and rehabilitative interventions are available to address special areas such as substance abuse, sexual abuse, sex offending, and domestic violence. Services are available in-home, at school, and in other community settings. The duration of MST intervention is three to five (3 to 5) months. MST involves families and other systems such as the school, probation officers, extended families, and community connections.

MST services are delivered in a team approach designed to address the identified needs of children and adolescents with significant behavioral problems who are transitioning from out of home placements or are at risk of out-of-home placement and need intensive interventions to remain stable in the community. This population has access to a variety of interventions twenty four (24/7) hours a day by staff that will maintain contact and intervene as one organizational unit.

This team approach is structured face-to-face therapeutic interventions to provide support and guidance in all areas of functional domains: adaptive, communication, psychosocial, problem solving, behavior management, etc. The service promotes the family's capacity to monitor and manage the youth's behavior.

A service order for MST must be completed by a physician, licensed psychologist, physician's assistant or nurse practitioner according to their scope of practice prior to or on the day that the services are to be provided.

Provider Requirements

MST services must be delivered by practitioners employed by a mental health/substance abuse provider organization that meets the provider qualification policies, procedures, and standards established by DMH and the requirements of 10A NCAC 27G. These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrate that they meet these standards by being endorsed by the LME. Within three years of enrollment as a provider, the organization must have achieved national accreditation. The organization must be established as a legally recognized entity in the United States and qualified/registered to do business as a corporate entity in the State of North Carolina.

MST providers must have the ability to deliver services in various environments, such as homes, schools, detention centers and jails (state funds only), homeless shelters, street locations, etc.

Organizations that provide MST must provide "first responder" crisis response on a 24/7/365 basis to consumers who are receiving this service

Staffing Requirements

This service model includes at a minimum a master's level QP who is the team supervisor and three (3) QP staff who provide available 24-hour coverage, 7 days per week. Staff is required to participate in MST introductory training and quarterly training on topics directly related to the needs of MST youth and their family on an ongoing basis. All staff on the MST team shall receive a minimum of one (1) hour of group supervision and one (1) hour of telephone consultation per week. MST team member to family ratio shall not exceed one to five (1 to 5) for each member.

Service Type/Setting

MST is a direct and indirect periodic service where the MST worker provides direct intervention and also arranges, coordinates, and monitors services on behalf of the recipient. This service is provided in any location. MST services are provided in a range of community settings such as recipient's home, school, homeless shelters, libraries, etc. MST also includes telephone time with the individual recipient and collateral contact with persons who assist the recipient in meeting their goals specified in their Person Centered Plan.

Note: For all services, federal Medicaid regulations will deny Medicaid payment for services delivered to inmates of public correctional institutions or for patients in facilities with more than 16 beds that are classified as Institutions of Mental Diseases.

Clinical Requirements

For registered recipients, a minimum of twelve (12) contacts must occur within the first month. For the second and third months of MST, an average of six (6) contacts per month must occur. It is the expectation that service frequency will be titrated over the last two (2) months.

Units will be billed in fifteen (15) minute increments.

Program services are primarily delivered face-to-face with the consumer and/or their family and in locations outside the agency's facility. The aggregate services that have been delivered by the agency will be assessed annually for each provider agency using the following quality assurance benchmarks:

- A minimum of fifty percent (50%) of the contacts occur face-to-face with the youth and/or family. The remaining units may either be phone or collateral contacts; and
- A minimum of sixty percent (60%) or more of staff time must be spent working outside of the agency's facility, with or on behalf of consumers.

Utilization Management

Authorization by the statewide vendor or the LME is required. The amount, duration, and frequency of the service must be included in an individual's Person Centered Plan. The initial authorization for services may not exceed thirty (30) days. Reauthorization will occur within a minimum sixty (60) days thereafter and is so documented in the Person Centered Plan and service record.

If it is a Medicaid covered service, utilization management will be done by the state vendor or the DHHS approved LME contracted with the Medicaid agency. If it is a non-covered Medicaid service or non-Medicaid client, then the utilization review will be done by the LME.

A maximum of thirty-two (32) units of MST services can be provided in a twenty-four (24) hour period. No more than 480 units of services can be provided to an individual in a three (3) month period unless specific authorization for exceeding this limit is approved.

Entrance Criteria

A. There is an Axis I or II diagnosis present, other than a sole diagnosis of Developmental Disability.

AND

B. The youth should be between the ages of 7 through 17.

AND

C. The youth displays willful behavioral misconduct (e.g., theft, property destruction, assault, truancy or substance use/abuse or juvenile sex offense), when in conjunction with other adjudicated delinquent behaviors

AND

D. The youth is at imminent risk of out-of-home placement or is currently in out-of-home placement due to delinquency and reunification is imminent within thirty (30) days of referral.

AND

E. The youth has a caregiver that is willing to assume long term parenting role and caregiver who is willing to participate with service providers for the duration of the treatment.

Continued Stay Criteria

The desired outcome or level of functioning has not been restored, improved or sustained over the time frame outlined in the youth's Person Centered Plan or the youth continues to be at risk for relapse based on history or the tenuous nature of the functional gains or any one of the following apply:

A. Youth continues to exhibit willful behavioral misconduct.

AND

B. There is a reasonable expectation that the youth will continue to make progress in reaching overarching goals identified in MST in the first four (4) weeks.

OR

C. Youth is not making progress; the Person Centered Plan must be modified to identify more effective interventions.

OR

D. Youth is regressing; the Person Centered Plan must be modified to identify more effective interventions.

Discharge Criteria

Youth's level of functioning has improved with respect to the goals outlined in the Person Centered Plan, or no longer benefits from this service. The decision should be based on one of the following:

A. Youth has achieved seventy-five percent (75%) of the Person Centered Plan goals, discharge to a lower level of care is indicated.

B. Youth is not making progress or is regressing, and all realistic treatment options within this modality have been exhausted.

C. The youth/family requests discharge and is not imminently dangerous to self or others

D. The youth requires a higher level of care (i.e., inpatient hospitalization or PRTF).

Note: Any denial, reduction, suspension, or termination of service requires notification to the recipient and/or legal guardian about their appeal rights.

Documentation Requirements

Minimum standard is a daily full service note that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, describes the provider's intervention, the time spent performing the intervention, the effectiveness of interventions and the signature of the staff providing the service.

Expected Outcomes

The youth has improved in domains such as: adaptive, communication, psychosocial, problem solving and behavior, willful behavioral misconduct ahs been reduced/eliminated (e.g. theft, property destruction, assault, truancy or substance abuse/use, or juvenile sex offense, when in conjunction with other delinquent behaviors) The family has increased capacity to monitor and manage the youth's behavior; need for out of home placement has been reduced/eliminated.

Service Exclusions/Limitations

An individual can receive MST services from only one MST provider organization at a time.

MST services can not be billed for individuals who are receiving Community Support, Intensive In-Home Services, Day Treatment, Hourly Respite, individual, group or family therapy, SAIOP, living in Level II-IV Child residential, or substance abuse residential placements except as specified below:

Service Limitation: CS can be billed for a maximum of 8 units per month in accordance with the person centered plan for individuals who are receiving MST services for the purpose of facilitating transition to the service, admission to the service, meeting with the person as soon as possible upon admission, providing coordination during the provision of service, ensuring that the service provider works directly with the CS profession and discharge planning.

Note: For recipients under the age of 21, additional products, services, or procedures may be requested even if they do not appear in the N.C. State Plan or when coverage is limited to those over 21 years of age. Service limitations on scope, amount, or frequency described in the coverage policy may not apply if the product, service, or procedure is medically necessary.

Community Support Team (CST) (MH/SA)
Medicaid Billable Service

Service Definition and Required Components

Community Support Team (CST) services consist of mental health and substance abuse rehabilitation services and supports necessary to assist adults (age 18 and older) in achieving rehabilitative and recovery goals. This is an intensive community rehabilitation service that provides treatment and restorative interventions to: assist individuals to gain access to necessary services; reduce psychiatric and addiction symptoms; and develop optimal community living skills. Services offered by the CST shall be documented in a Person Centered Plan and must include: assistance and support for the individuals in crisis situations; service coordination; psycho-education and support for individuals and their families; individual restorative interventions for the development of interpersonal, community coping and independent living skills; development of symptom monitoring and management skills; monitoring medication; and self medication.

Individuals will experience decreased crisis episodes, and increased community tenure, time working, in school or with social contacts, and personal satisfaction and independence. Through supports based on the individuals' needs, consumers will reside in independent or semi-independent living arrangements, and be engaged in the recovery process.

The CST must consult with identified professionals, family members and others, include their input into the Person Centered Planning process, inform all involved stakeholders, and monitor the status of the recipient in relationship to the treatment goals. The CST provider assumes the roles of advocate, broker, coordinator, and monitor of the service delivery system on behalf of the recipient. The community Support Professional provides coordination of movement across levels of care, directly to the person and their family, and coordinates discharge planning and community re-entry following hospitalization, residential services and other levels of care.

A service order for CST must be completed by a physician, licensed psychologist, physician's assistant or nurse practitioner according to their scope of practice prior to or on the day that the services are to be provided.

Provider Requirements

Community Support services provided by a team must be delivered by practitioners employed by a mental health/substance abuse provider organization that meet the provider qualification policies. These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrate that they meet these standards by being endorsed by the LME. Within three (3) years of enrollment as a provider, the organization must have achieved national accreditation. The organization must be established as a legally recognized entity in the United States and qualified/registered to do business in the State of North Carolina.

The CST must have the ability to deliver services in various environments, such as homes, schools, jails (state funds only), homeless shelters, street locations, etc.

Organizations that provide CST services must provide "first responder" crisis response on a 24/7/365 basis to consumers who are receiving this service.

Staffing Requirements

Community Support teams must be comprised of three (3) staff persons meeting the requirements above. Each team must have a team leader who must meet QP status according to 10A NCAC 27G.0104. The team must have a least a .5 FTE team leader that provides clinical and administrative supervision of the team and also function as a practicing clinician on the team.

AND

Persons who meet the requirements specified for QP or AP status according to 10A NCAC 27G.0104 and who have the knowledge, skills and abilities required by the population and age to be served may deliver Community Support Team services. A QP must be the team leader (supervisor). Supervision is provided according to supervision requirements specified in 10A NCAC 27G.0203 and according to licensure requirements of the appropriate discipline.

AND

The team may include a paraprofessional who meet the requirements specified for Paraprofessional status according to 10A NCAC 27G.0104 and who have the knowledge, skills and abilities required by the population and age to be served may deliver Community Support Team services within the requirements of the staff definition specific in the above role. Supervision of Paraprofessionals is also to be carried out according to 10A NCAC 27G.0204.

OR

A Certified Peer Support Specialist is an individual who is or has been a recipient or is a recipient of mental health or substance abuse services with mental illness or addiction. A Certified Peer Specialist is a fully integrated team member who provides highly individualized services in the community and promotes individual self-determination and decision making.

The Community Support Team maintains a consumer-to-practitioner ratio of no more than fifteen (15) consumers per staff person. Staff-to-consumer ratio takes into consideration evening and weekend hours, needs of special populations, and geographical areas to be served. (For example, a team of three staff can have a caseload of 45 consumers.)

All staff providing community support team services must have a minimum of one year documented experience with the adult population and completion of a minimum of twenty hours of crisis management and community support team service definition required components within the first 90 days of employment.

Service Type/Setting

Community Support Team is a direct and indirect periodic service in which the team provides direct intervention and also arranges, coordinates, and monitors services on behalf of the recipient. This service is provided in any location. Community Support Team services are provided in a range of community settings such as recipient's home, homeless shelters, libraries, etc. Community Support Team services also include telephone time with the individual recipient and collateral contact with persons who assist the recipient in meeting his/her rehabilitation goals.

This service is billable to Medicaid except when provided to a consumer who is an inmate of a public correctional institution or a resident in an Institution for Mental Diseases (IMD).

Clinical Requirements

For registered recipients, a minimum of eight (8) contacts must occur within the first month. Units will be billed in fifteen (15) minute increments.

Program services are primarily delivered face-to-face with the consumer and in locations outside the agency's facility. The aggregate services that have been delivered by the agency will be assessed annually for each provider agency using the following quality assurance benchmarks:

- A minimum of sixty percent (60%) or more of CST services that are delivered face-to-face with the recipient. The remaining units may either by phone or collateral contacts; and
- A minimum of ninety percent (90%) or more of staff time must be spent working outside of the agency's facility, with or on behalf of consumers.

Utilization Management

Authorization by the statewide vendor or by the LME is required. The amount, duration and frequency of the service must be included in an individual's Person Centered Plan and a QP must obtain service orders prior to the delivery of services. The initial authorization for services may not exceed 30 days. Reauthorization will occur within a minimum of 60 days thereafter and is to be documented in the Person Centered Plan and service record.

If it is a Medicaid covered service, utilization management will be done by the state vendor or the DHHS approved LME contracted with the Medicaid agency. If it is a non-covered Medicaid service or non-Medicaid client, then the utilization review will be done by the LME.

A maximum of 32 units of CST services can be provided in a 24-hour period, unless specific authorization for exceeding this limit is appropriate. No more than 140 units of services per week can be provided to an individual unless specific authorization for exceeding this limit is required based on medical necessity.

Entrance Criteria

The recipient is eligible for this service when:

A. There are two (2) identified needs in the appropriate documented domains,

AND

B. There is an Axis I or II diagnosis present, other than a sole diagnosis of a Developmental Disability

AND/OR

C. Adult of Care Criteria or level A/ASAM (American Society for Addiction Medicine)

AND

D. And four or more of the following conditions:

1. High use of acute psychiatric hospitals or crisis/emergency services including mobile, in-clinic or crisis residential (e.g., two or more admissions per year) or extended hospital stay (30 days within the past year) or psychiatric emergency services.
2. History of inadequate follow-through with elements of a Person Centered Plan related to risk factors (including lack of follow through taking medications, following a crisis plan or maintaining housing).
3. Intermittently medication refractory.
4. Co-diagnosis of substance abuse (ASAM – any level of care) and mental illness.
5. Legal issues (conditional release for non-violent offense; history of failures to show in court, etc.).

6. Homeless or at high risk of homelessness due to residential instability.
7. Clinical evidence of suicidal gestures and/or ideation in past 3 months.
8. Ongoing inappropriate public behavior in the community within the last three months.
9. Self-harm or threats of harm to others within last year.
10. Evidence of significant complications such as cognitive impairment, behavioral problems, or medical conditions.
11. A lower level of care has been tried or considered and found to be inappropriate for the consumer at the time that authorization is requested.

Continued Stay Criteria

The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the recipient's Person Centered Plan or the recipient continues to be at risk for relapse based on history or the tenuous nature of the functional gains or any one of the following apply:

A. Recipient has achieved initial Person Centered Plan goals and these services are necessary to meet additional goals.

B. Recipient is making satisfactory progress toward meeting goals.

C. Recipient is making some progress, but the Person Centered Plan (specific interventions) need to be modified so that greater gains, which are consistent with the recipient's premorbid level of functioning, are possible or can be achieved.

D. Recipient is not making progress; the Person Centered Plan must be modified to identify more effective interventions.

E. Recipient is regressing; the Person Centered Plan must be modified to identify more effective interventions.

AND

Utilization review must be conducted every 60 days (after the initial 30 day UR) and is so documented in the Person Centered Plan and service record.

Discharge Criteria

Recipient's level of functioning has improved with respect to the goals outlined in the Person Centered Plan, inclusive of a transition plan to step down, or no longer benefits, or has the ability to function at this level of care and any of the following apply:

A. Recipient has positive life outcomes that supports stable and ongoing recovery.

B. Recipient is not making progress, or is regressing and all realistic treatment options have been exhausted indicating a need for more intensive services.

C. Recipient/family no longer wants Community Support Team services.

Note: Any denial, reduction, suspension, or termination of service requires notification to the recipient and/or legal guardian about their appeal rights.

Documentation Requirements

Minimum standard is a daily full service note that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, describes the provider's interventions, includes the time spent performing the interventions, effectiveness of the intervention, and the signature and credentials of the staff providing the service.

Expected Outcomes

Individuals will experience decreased crisis episodes and increased community tenure, time working in school or with social contact, and personal satisfaction and independence. Through supports based on the individuals' needs, consumers will reside in independent or semi-independent living arrangements, and be engaged in the recovery process

Service Exclusions/Limitations

An individual can receive Community Support Team services from only one Community Support Team provider at a time.

Community Support Team services can not be billed for individuals who are receiving Community Support, ACTT, SA Intensive Outpatient Program (SAIOP), SA Comprehensive Outpatient Treatment (SACOT) or SA residential services except as specified below.

Community Support Team services can be billed for a maximum of eight (8) units per month in accordance with the PCP for individuals who are receiving Community Support, ACTT, Partial Hospitalization, SAIOP, SACOT, or residential services for the purpose of facilitating a transition for the service, admission to the service, meeting with the person as soon as possible upon admission, providing coordination during the provision of service, and ensuring that the service provider works directly with the CST professional and discharge planning.

Community Support Team services can be provided for individuals residing in adult MH residential programs (e.g., Supervised Living Low or Moderate, Group Living Low, Moderate or High).

Note: For recipients under the age of 21, additional products, services, or procedures may be requested even if they do not appear in the N.C. State Plan or when coverage is limited to those over 21 years of age. Service limitations on scope, amount, or frequency described in the coverage policy may not apply if the product, service, or procedure is medically necessary.

Assertive Community Treatment Team (ACTT)
Medicaid Billable Service

Service Definition and Required Components

The Assertive Community Treatment Team is a service provided by an interdisciplinary team that ensures service availability 24 hours a day, 7 days per week and is prepared to carry out a full range of treatment functions wherever and whenever needed. A service recipient is referred to the Assertive Community Treatment Team service when it has been determined that his/her needs are so pervasive and/or unpredictable that they can not be met effectively by any other combination of available community services. Typically this service should be targeted to the ten percent (10%) of MH/DD/SA service recipients who have serious and persistent mental illness or co-occurring disorders, dual and triply diagnosed and the most complex and expensive treatment needs. The service objectives are addressed by activities designed to: promote symptom stability and appropriate use of medication; restore personal, community living and social skills; promote and maintain physical health; establish access to entitlements, housing, work and social opportunities; and promote and maintain the highest possible level of functioning in the community. ACT Teams should make every effort to meet critical standards contained in the most current edition of the National Program Standards for ACT Teams as established by the National Alliance for the Mentally Ill or US Department of Health and Human Services, Center for Mental Health Services.

This service is delivered in a team approach designed to address the identified needs of specialized populations and/or the long term support of those with persistent MH/DD/SA issues that require intensive interventions to remain stable in the community. These service recipients would tend to be high cost, receive multiple services, decompensate to the point of requiring hospitalization before seeking treatment, seek treatment only during a crisis, or unable to benefit from traditional forms of clinic based services. This population has access to a variety of interventions twenty four (24) hours, seven days per week by staff that will maintain contact and intervene as one organizational unit.

This team approach involves structured face-to-face scheduled therapeutic interventions to provide support and guidance in all areas of functional domains: adaptive, communication, personal care, domestic, psychosocial, problem solving, etc. in preventing, overcoming, or managing the recipient's level of functioning and enhancing his/her ability to remain in the community.

This service includes interventions that address the functional problems associated with the most complex and/or pervasive conditions of the identified population. These interventions are strength based and focused on promoting symptom stability, increasing the recipient's ability to cope and relate to others and enhancing the highest level of functioning in the community.

ACTT provides ongoing assertive outreach and treatment necessary to address the service recipient's needs effectively. Consideration of geographical locale may impact on the effectiveness of this service model. This model is primary a mobile unit, but includes some clinic based services.

A service order for ACTT must be completed by a physician, licensed psychologist, physician’s assistant or nurse practitioner according to their scope of practice prior to or on the day that the services are to be provided.

Provider Requirements

Assertive Community Treatment services must be delivered by practitioners employed by a mental health/substance abuse provider organization that meet the provider qualification policies, procedures, and standards established by DMH and the requirements of 10A NCAC 27G . These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrate that they meet these standards by being endorsed by the LME. Within three years of enrollment as a provider, the organization must have achieved national accreditation. The organization must be established as a legally recognized entity in the United States and qualified/registered to do business in the State of North Carolina.

ACTT services may be provided to an individual by only one organization at a time. This organization is identified in the Person Centered Plan and is responsible for obtaining authorization from the LME for the PCP. ACTT providers must have the ability to deliver services in various environments, such as homes, schools, homeless shelters, street locations, etc.

***Note:** For all services, federal Medicaid regulations will deny Medicaid payment for services delivered to inmates of public correctional institutions. For ACTT, the case management component may be billed when provided thirty (30) days prior to discharge when a recipient resides in a general hospital or a psychiatric inpatient setting and retains Medicaid eligibility.

Organizations that provide ACTT services must ensure service availability 24 hours per day, 7 days per week, 365 days per year and be capable of providing a full range of treatment functions including crisis response wherever and whenever needed to recipients who are receiving ACTT services.

Staffing Requirements

Assertive Community Treatment services must be provided by a team of individuals. Individuals on this team shall have sufficient individual competence, professional qualifications and experience to provide service coordination; crisis assessment and intervention; symptom assessment and management; individual counseling and psychotherapy; medication prescription, administration, monitoring and documentation; substance abuse treatment; work-related services; activities of daily living services; social, interpersonal relationship and leisure-time activity services; support services or direct assistance to ensure that individuals obtain the basic necessities of daily life; and education, support, and consultation to individuals' families and other major supports. Each ACT team staff member must successfully participate in the DMH approved ACTT training. The DMH approved training will focus on developing staff's competencies for delivering ACTT services according to the most recent evidenced based practices. Each ACT team shall have sufficient numbers of staff to provide treatment, rehabilitation, and support services 24 hours a day, seven days per week.

Each ACT team shall have a staff-to-individual ratio that does not exceed one full-time equivalent (FTE) staff person for every 10 individuals (not including the psychiatrist and the program assistant ACT teams **that serve approximately 100 individuals** shall employ a minimum of 10 FTE multidisciplinary clinical staff persons including:

***Team Leader*:** A full-time team leader/supervisor that is the clinical and administrative supervisor of the team and who also functions as a practicing clinician on the ACTT team. The team leader at a minimum must have a mater's level QP status according to 10A NCAC 27G.0104.

***Psychiatrist*:** A psychiatrist, who works on a full-time or part-time basis for a minimum of 16 hours per week for every 50 individuals. The psychiatrist provides clinical services to all ACTT individuals; works with the team leader to monitor each individual's clinical status and response to treatment; supervises staff delivery of services; and directs psychopharmacologic and medical services.

***Registered Nurses*:** A minimum of two FTE registered nurses. At least one nurse must have a QP status according to 10A NCAC 27G.0104 or be an Advanced Practice Nurse (APN) according to NCGS Chapter 90 Article I, Subchapter 32M. The other nurse must have at minimum an AP status according to 10A NCAC 27G.0104. By July 1, 2005 it is expected that all team nurses will be have QP Status or be an APN.

***Other Mental Health Professionals*:** A minimum of 4 FTE QP or AP (in addition to the team leader), with at least one designated for the role of vocational specialist, preferably with a master's degree in rehabilitation counseling. At least one-half of these other mental health staff shall be master's level professionals.

***Substance Abuse Specialist*:** One FTE who has a QP status according to 10A NCAC 27G.0104. and is one of the following: CCS, CCAS, or CSAC.

***Certified Peer Support Specialist*:** A minimum of one FTE Certified Peer Support Specialist. A Certified Peer Support Specialist is an individual who is or has been a recipient of mental health services. Because of life experience with mental illness and mental health services, the Certified Peer Support Specialist provides expertise that professional training cannot replicate. Certified Peer Support Specialists are fully integrated team members who provide highly individualized services in the community and promote individual self-determination and decision-making.

Certified Peer Support Specialists also provide essential expertise and consultation to the entire team to promote a culture in which each individual's point of view and preferences are recognized, understood, respected and integrated into treatment, rehabilitation, and community self-help activities.

***Remaining Clinical Staff*:** The additional clinical staff may be bachelor's level and Paraprofessional mental health workers who carry out rehabilitation and support functions. A bachelor's level mental health worker has a bachelor's degree in social work or a behavioral science and work experience with adults with severe and persistent mental illness. A Paraprofessional mental health worker may have a bachelor's degree in a field other than behavioral sciences or have a high school degree and work experience with adults with severe and persistent mental illness or with individuals with similar human-services needs. These Paraprofessionals may have related training (e.g., certified occupational therapy assistant, home health care aide) or work experience (e.g., teaching) and life experience.

Program/Administrative Assistant: One FTE program/administrative assistant who is responsible for organizing, coordinating, and monitoring all non-clinical operations of ACTT, including managing medical records; operating and coordinating the management information system; maintaining accounting and budget records for individual and program expenditures; and providing receptionist activities, including triaging calls and coordinating communication between the team and individuals.

Smaller teams **serving no more than 50 individuals** shall employ a minimum of 6 to 8 FTE multidisciplinary clinical staff persons, including one team leader (MHP), one registered nurse, one FTE peer specialist, one FTE program assistant, and 16 hours of psychiatrist time for every 50 individuals on the team. One of the multidisciplinary clinical staff persons should be a CCS or CCAS, CSAC.

Service Type/Setting

ACTT is a direct and indirect periodic service where the ACTT staff provides direct intervention and also arranges, coordinates, and monitors services on behalf of the recipient. This service is provided in any location. ACTT are intended to be provided on an individualized basis.

ACTT services are primarily provided in a range of community settings such as recipient's home, school, homeless shelters, libraries, etc.

***Note:** For all services, federal Medicaid regulations will deny Medicaid payment for services delivered to inmates of public correctional institutions. For ACTT, the case management component may be billed when provided thirty (30) days prior to discharge when a recipient resides in a general hospital or a psychiatric inpatient setting and retains Medicaid eligibility.

ACTT may include telephone time with the individual recipient and collateral contact with persons who assist the recipient in meeting his/her rehabilitation goals. ACTT activities include person-centered planning meetings and meetings for treatment/Person Centered Plan development.

Program Requirements

The ACT team shall have the capacity to provide multiple contacts a week with individuals experiencing severe symptoms, trying a new medication, experiencing a health problem or serious life event, trying to go back to school or starting a new job, making changes in living situation or employment or having significant ongoing problems in daily living. These multiple contacts may be as frequent as two to three times per day, seven days per week and depend on individual need and a mutually agreed upon plan between individuals and program staff. Many, if not all, staff shall share responsibility for addressing the needs of all individuals requiring frequent contact. The ACT team shall provide an average of three contacts per week for all individuals.

Program services are primarily delivered face-to-face with the consumer and in locations outside the agency's facility. The aggregate services that have been delivered by the agency will be assessed annually for each provider agency using the following quality assurance benchmarks:

- A minimum of eighty percent (80%) or more of staff time must be face-to-face with the recipient. The remaining units may either be phone or collateral contacts; and
- Each team shall set a goal of providing seventy-five percent (75%) of service contacts in the community in non office-based or non facility-based settings.

To ensure appropriate ACT team development, each new ACT team is recommended to titrate ACTT intake (e.g., 4-6 individuals per month) to gradually build up capacity to serve no more than 100-120 individuals (with 10-12 staff) and no more than 42-50 individuals (with 6-8 staff) for smaller teams.

The ACT team shall be available to provide treatment, rehabilitation, and support activities seven days per week. It is recommended that ACT team schedules should follow the standards established in the National Program Standards for ACT Teams.

Utilization Management

Authorization by the statewide vendor or by the LME if approved by DHHS is required. Utilization review must be conducted every thirty (30) days and is so documented in the Person Centered Plan and service record.

If it is a Medicaid covered service, utilization management will be done by the state vendor or the DHHS approved LME contracted with the Medicaid agency. If it is a non-covered Medicaid service or non-Medicaid client, then the utilization review will be done by the LME.

Entrance Criteria

The recipient is eligible for ACTT services when:

A. They have a severe and persistent mental illness listed in the diagnostic nomenclature (currently he Diagnostic and Statistical Manual, Fourth Edition, or DSM IV, of the American Psychiatric Association) that seriously impair their functioning in community living. Priority is given to people with schizophrenia, other psychotic disorders (e.g., schizoaffective disorder), and bipolar disorder because these illnesses more often cause long-term psychiatric disability. (Individuals with a primary diagnosis of a substance abuse disorder or mental retardation are not the intended recipient group.)

B. They have a significant functional impairments as demonstrated by at least one of the following conditions:

   1. Significant difficulty consistently performing the range of practical daily living tasks required for basic adult functioning in the community (e.g., caring for personal business affairs; obtaining medical, legal, and housing services; recognizing and avoiding common dangers or hazards to self and possessions; meeting nutritional needs; maintaining personal hygiene) or persistent or recurrent difficulty performing daily living tasks except with significant support or assistance from others such as friends, family, or relatives.
   2. Significant difficulty maintaining consistent employment at a self-sustaining level or significant difficulty consistently carrying out the homemaker role (e.g., household meal preparation, washing clothes, budgeting, or child-care tasks and responsibilities).
   3. Significant difficulty maintaining a safe living situation (e.g., repeated evictions or loss of housing).

C. Have one or more of the following problems, which are indicators of a need for continuous high level of services (i.e., greater than eight hours per month):

   1. High use of acute psychiatric hospitals (e.g., two or more admissions per year) or psychiatric emergency services.
   2. Intractable (i.e., persistent or very recurrent) severe major psychiatric symptoms (e.g., affective, psychotic, suicidal).
   3. Coexisting mental health and substance abuse disorder of significant duration (e.g., greater than 6 months).
   4. High risk or recent history of criminal justice involvement (e.g., arrest, incarceration).
   5. Significant difficulty meeting basic survival needs, residing in substandard housing, homelessness or imminent risk of becoming homeless.
   6. Residing in an inpatient or supervised community residence, but clinically assessed to be able to live in a more independent living situation if intensive services are provided, or requiring a residential or institutional placement if more intensive services are not available.
   7. Difficulty effectively utilizing traditional office-based outpatient services.

Priority is given to people with schizophrenia, other psychotic disorders (e.g., schizoaffective disorder), and bipolar disorder. Individuals with other major psychiatric disorders may be eligible when other services have not been effective in meeting their needs.

Continued Stay Criteria

The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the recipient's Person Centered Plan or the recipient continues to be at risk for relapse based on attempts to reduce ACTT services in a planful way; or the tenuous nature of the functional gains; or any one of the following apply:

A. Recipient has achieved positive life outcomes that supports stable and ongoing recovery and these services are needed to meet additional goals.

B. Recipient is making satisfactory progress toward meeting goals.

C. Recipient is making some progress, but the Person Centered Plan (specific interventions) needs to be modified so that greater gains, which are consistent with the recipient's premorbid level of functioning, are possible or can be achieved.

D. Recipient is not making progress; the Person Centered Plan must be modified to identify more effective interventions or indicating a need for more intensive services.

E. Recipient is regressing; the Person Centered Plan must be modified to identify more effective interventions.

If the recipient is functioning effectively with this service and discharge would otherwise be indicated, ACTT services should be maintained when it can be reasonably anticipated that regression is likely to occur if the service is withdrawn. The decision should be based on any one of the following:

A. Past history of regression in the absence of ACTT is documented in the service record or attempts to titrate ACTT downward have resulted in regression,

OR

B. In the event there is an epidemiologically sound expectation that symptoms will persist and that ongoing outreach treatment interventions are needed to sustain functional gains. The presence of a DSM IV diagnosis would necessitate a disability management approach.

Discharge Criteria

A. Discharges from the ACT team occur when recipients and program staff mutually agree to the termination of services. This shall occur when recipients:

   1. Have successfully reached individually established goals for discharge, and when the recipient and program staff mutually agree to the termination of services.

   2. Have successfully demonstrated an ability to function in all major role areas (i.e., work, social, self-care) without ongoing assistance from the program, without significant relapse when services are withdrawn, and when the recipient requests discharge, and the program staff mutually agree to the termination of services.

   3. Move outside the geographic area of ACTT's responsibility. In such cases, the ACT team shall arrange for transfer of mental health service responsibility to an ACTT program or another provider wherever the recipient is moving. The ACT team shall maintain contact with the recipient until this service transfer is implemented.

   4. Decline or refuse ACTT services and request discharge, despite the team's best efforts to develop an acceptable treatment plan with the recipient.

B. Documentation of discharge shall include:

1. The reasons for discharge as stated by both the recipient and the ACT team.
2. The recipient's biopsychosocial status at discharge.
3 A written final evaluation summary of the recipient's progress toward the goals set forth in the treatment plan.
4. A plan developed in conjunction with the recipient for follow-up treatment after discharge.
5. The signature of the recipient, the recipient's service coordinator, the team leader, and the psychiatrist.

Note: Any denial, reduction, suspension, or termination of service requires notification to the recipient and/or legal guardian about their appeal rights.

Documentation Requirements

Minimum standard is a daily full service note that includes the consumer's name, Medicaid identification number, date of service, purpose of contact, describes the provider's interventions, includes the time spent performing the interventions, effectiveness of the intervention, and the signature of the staff providing the service.

Expected Outcomes

The individual will have increased ability to function in all major role areas (i.e., work, social, self-care) without ongoing assistance from the program, without significant relapse when services are withdrawn, need for emergency and inpatient psychiatric services will be reduced; severe psychiatric symptoms will be reduced, criminal justice involvement will be decreased, ability to meet basic needs such as food, clothing, housing will be increased.

Service Exclusions/Limitations

An individual can receive ACTT services from only one ACTT provider at a time. ACTT is a comprehensive team intervention and most other services are excluded. Opioid Treatment can be provided concurrently with ACTT.

ACTT services can be billed for a limited period of time in accordance with the PCP for individuals who are receiving Community Support, CST, Partial Hospitalization, SAIOP, SACOT, PSR, or SA residential services for the purpose of facilitating transition to the service admission to the service, meeting with the person as soon as possible upon admission, providing coordination during the provision of service, ensuring that the service provider works directly with the ACTT professional and discharge planning.

ACTT services can be provided for individuals residing in adult MH residential programs (e.g. Supervised Living Low or Moderate, Group Living Low, Moderate or High).

Note:
For recipients under the age of 21, additional products, services, or procedures may be requested even if they do not appear in the N.C. State Plan or when coverage is limited to those over 21 years of age. Service limitations on scope, amount, or frequency described in the coverage policy may not apply if the product, service, or procedure is medically necessary.

Psychosocial Rehabilitation
Medicaid Billable Service

Service Definition and Required Components

A Psychosocial Rehabilitation (PSR) service is designed to help adults with psychiatric disabilities increase their functioning so that they can be successful and satisfied in the environments of their choice with the least amount of ongoing professional intervention. PSR focuses on skill and resource development related to life in the community and to increasing the participant's ability to live as independently as possible, to manage their illness and their lives with as little professional intervention as possible, and to participate in community opportunities related to functional, social, educational and vocational goals.

The service is based on the principles of recovery, including equipping consumers with skills, emphasizing self-determination, using natural and community supports, providing individualized intervention, emphasizing employment, emphasizing the "here and now", providing early intervention, providing a caring environment, practicing dignity and respect, promoting consumer choice and involvement in the process, emphasizing functioning and support in real world environments, and allowing time for interventions to have an effect over the long term.

There should be a supportive, therapeutic relationship between the providers, recipient, and family which addresses and/or implements interventions outlined in the Person Centered Plan in any of the following skills development, educational, and pre-vocational activities:

A. community living, such as housekeeping, shopping, cooking, use of transportation facilities, money management;

B. personal care such as health care, medication self-management, grooming;

C. social relationships;

D. use of leisure time

E. educational activities which include assisting the client in securing needed education services such as adult basic education and special interest courses; and

F. prevocational activities which focus on the development of positive work habits and participation in activities that would increase the participant's self worth, purpose and confidence; these activities are not to be job specific training.

A service order for Psychosocial Rehabilitation must be completed by a physician, licensed psychologist, physician's assistant or nurse practitioner according to their scope of practice prior to or on the day that the services are to be provided.

Provider Requirements

Psychosocial Rehabilitation services must be delivered by a mental health provider organization that meet the provider qualification policies, procedures, and standards established by DMH and the requirements of 10A NCAC 27G These policies and procedures set forth the administrative, financial, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrate that they meet these standards by being endorsed by the LME. Within three years of enrollment as a provider, the organization must have achieved national accreditation. The organization must be established as a legally recognized entity in the United States and qualified/registered to do business as a corporate entity in the State of North Carolina.

Staffing Requirements

The program shall be under the direction of a person who meets the requirements specified for QP status according to 10A NCAC 27G.0104. The QP is responsible for supervision of other program staff which may include APs and Paraprofessionals who meet the requirements according to 10A NCAC 27G.0104 and who have the knowledge, skills and abilities required by the population and age to be served.

Service Type/Setting

Psychosocial Rehabilitation is a service that shall be available five hours a day minimally and the setting shall meet the licensure requirements of 10A NCAC 27G.1200.

Program Requirements

This service is to be available for a period of five or more hours per day at least five days per week and it may be provided on weekends or in the evening. The number of hours that participant receives PSR services are to be specified in his/her Person Centered Plan.

If the PSR provider organization also provides Supported Employment or Transitional Employment, these services are to be costed and reported separately.

Only the time during which the participant receives PSR services may be billed to Medicaid.

Utilization Management

Authorization by the statewide vendor or the LME is required. The amount, duration, and frequency of services must be included in an individual's Person Centered Plan, and authorized on or before the day services are to be provided. Initial authorization for services would not exceed a six (6) month period. Utilization review must be conducted every 6 months and be so documented in the service record.

If it is a Medicaid covered service, utilization management will be done by the state vendor or the DHHS approved LME contracted with the Medicaid agency. If it is a non-covered Medicaid service or non-Medicaid client, then the utilization review will be done by the LME.

Entrance Criteria:

The recipient is eligible for this service when:

A. There is an Axis I or II diagnosis present,

AND

B. Level of Care Criteria

AND

C. The recipient has impaired role functioning that adversely affects at least two of the following:
   1. employment,
   2. management of financial affairs,
   3. ability to procure needed public support services,
   4. appropriateness of social behavior, or
   5. activities of daily living.

AND

D. The recipient's level of functioning may indicate a need for psychosocial rehabilitation if the recipient has unmet needs related to recovery and regaining the skills and experience needed to maintain personal care, meal preparation, housing, or to access social, vocational and recreational opportunities in the community.

Continued Stay Criteria

The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the recipient's person centered plan or the recipient continues to be at risk for relapse based on history or the tenuous nature of the functional gains or any one of the following apply:

A. Recipient has achieved initial rehabilitation goals in the person centered plan goals and continued services are needed in order to achieve additional goals.

B. Recipient is making satisfactory progress toward meeting rehabilitation goals.

C. Recipient is making some progress, but the specific interventions need to be modified so that greater gains, which are consistent with the recipient's rehabilitation goals are possible or can be achieved.

D. Recipient is not making progress; the rehabilitation goals must be modified to identify more effective interventions.

E. Recipient is regressing; the person centered plan must be modified to identify more effective interventions.

Discharge Criteria

Recipient's level of functioning has improved with respect to the rehabilitation goals outlined in the person centered plan, inclusive of a transition plan to step down, or no longer benefits, or has the ability to function at this level of care and any of the following apply:

A. Recipient has achieved rehabilitation goals, discharge to a lower level of care is indicated.

B. Recipient is not making progress, or is regressing and all realistic treatment options with this modality have been exhausted.

C. Recipient requires a more intensive level of care or service.

Note: Any denial, reduction, suspension, or termination of service requires notification to the recipient and/or legal guardian about their appeal rights.

Expected Outcomes

This service includes interventions that address the functional problems associated with complex and/or complicated conditions related to mental illness. These interventions are strength-based and focused on promoting recovery, symptom stability, increased coping skills and achievement of the highest level of functioning in the community. The focus of interventions is the individualized goals related to addressing the recipient's daily living, financial management and personal development; developing strategies and supportive interventions that will maintain stability; assisting recipients to increase social support skills that ameliorate life stresses resulting from the recipient's mental illness.

Documentation Requirements

Minimum standard is a daily service note that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, describes the provider's intervention, the time spent performing the intervention, the effectiveness of interventions and the signature of the staff providing the service.

Service Exclusions

PSR cannot be provided during the same authorization period with the following services: Partial hospitalization and ACTT.

Note: For recipients under the age of 21, additional products, services, or procedures may be requested even if they do not appear in the N.C. State Plan or when coverage is limited to those over 21 years of age. Service limitations on scope, amount, or frequency described in the coverage policy may not apply if the product, service, or procedure is medically necessary.

Child and Adolescent Day Treatment (MH/SA)
Medicaid Billable Service

Service Definition and Required Components

Day Treatment includes a structured treatment service program that builds on the strengths and addresses the identified functional problems associated with the complex conditions of each individual child or adolescent and family. These interventions are designed to support symptom reduction and/or sustain symptom stability at lowest possible levels, increase the individual's ability to cope and relate to others, support and sustain recovery, and enhance the child's capacity to function in an inclusive setting or to be maintained in community based services. It is available for children 3 to 17 years of age (20 or younger for those who are eligible for Medicaid).

Day Treatment provides mental health and/or substance abuse interventions in the context of a treatment milieu. This service should be focused on achieving functional gains, be developmentally appropriate, culturally relevant and sensitive, child and family centered and focus on reintegrating the individual back into the school or transitioning into employment. The outcomes and therapeutic or rehabilitation goals of this service are defined in individual treatment goals outlined in the PCP/Child and Family Plan. The Child and Family Team, are those persons relevant to the child's successful achievement of service goals including, but not limited to, family members, mentors, school personnel and members of the community who may provide support, structure, and services for the child.

Intensive services are designed to reduce symptoms and improve functional skills. Functional skills shall include, but are not limited to:

- Functioning in a mainstream educational setting;
- Maintaining residence with a family or community based non-institutional setting (foster home, therapeutic home, residential treatment, etc.); and
- Maintaining appropriate role functioning in community settings.

In addition to traditional therapeutic interventions, day treatment may also include time spent off site in places that are related to achieving service goals including, but not limited to, normalizing community activities, such as visiting a local place of business to file an application for part time employment. For younger children, relationship and play-based therapies should be delivered in a natural setting.

Best practices include a supportive, therapeutic relationship between the providers and consumer and family/caregiver that addresses and/or implements specific interventions outlined in the PCP/Child and Family Plan. These shall include, but are not limited to, any of the following:

- Behavioral/symptom interventions/management,
- Social and other therapeutically relevant skill development,
- Adaptive skill training,
- Enhancement of communication and problem-solving skills,
- Anger management,
- Family support, including training of family/caregivers and others who have a legitimate role in addressing the needs identified in the Person Centered Plan
- Monitoring of psychiatric symptoms and self management of symptoms/behaviors,
- Relapse prevention and disease management strategies, and
- Related positive behavior support activities and reinforcements.

In addition, Day Treatment provides case management services including, but not limited to, the following:

- Assessing the child's needs for comprehensive services
- Linking the child and/or family to needed services and supports
- Monitoring the provision of services and supports
- Assessing the outcomes of services and supports
- Convening Child and Family Team meetings to coordinate the provision of multiple services and ensure appropriate modification of the PCP over time.

Children and adolescents may be residents of their own home or a substitute home. However, the day treatment shall be provided in a setting separate from the consumer's residence.

A service order for child and adolescent Day Treatment must be completed by a physician, licensed psychologist, physician's assistant or nurse practitioner according to their scope of practice prior to or on the day that the services are to be provided.

Provider Requirements

Day Treatment shall be delivered by a provider organization that meet the provider qualification policies, procedures and standards established by DMH and the requirements of 10A NCAC 27G These policies and procedures set forth the administrative, financial, clinical, quality improvement and information services infrastructure necessary to provide services. Provider organizations shall demonstrate that they meet these standards by being endorsed by the LME. Within three years of enrollment as a provider, the organization must have achieved national accreditation. The provider organization shall be established as a legally recognized entity in the United States and qualified/registered to do business in the State of North Carolina.

Staffing Requirements

A program director who meets the requirements specified for a QP and has a minimum of two years experience in child and adolescent mental health/substance abuse treatment services must be present in developing and implementing services. Minimum ratio of one QP staff to every six consumers is required to be present. The minimum ~~of~~ staff to consumer ratio shall be present with the consumers at all times and staffing configuration must be adequate to anticipate and meet consumer needs. Psychiatric consultation shall be available for each consumer.

Day Treatment includes professional services on an individual and group basis in a structured community based setting. Persons who meet the requirements specified for QP or AP status according to 10A NCAC 27G.0104 may deliver Day Treatment. Supervision is provided according to supervision requirements specified in 10A NCAC 27G.0203 and according to licensure requirements of the appropriate discipline. Paraprofessional level providers who meet the requirements specified for Paraprofessional status and who have the knowledge, skills and abilities required by the population and age to be served may deliver Day Treatment within the requirements of the staff definition specific in the above role. When a Paraprofessional provides Day Treatment services, a QP or AP is responsible for overseeing the development of the recipient's Person Centered Plan/Child and Family Plan. When Paraprofessionals provide Day Treatment services, they shall be under the supervision of a QP or AP. Supervision of Paraprofessionals is to be carried out according to 10A NCAC 27G.0204.

For programs providing services to children with primary substance abuse or dependence diagnoses: Persons who meet the requirements specified for CCS, CCAS, and CSAC under Article 5C may deliver Day Treatment services. Services may also provided by staff who meet the requirements specified for QP or AP status according to 10A NCAC 27G.0104, under the supervision of a CCAS or CCS. Paraprofessional level providers who meet the requirements for Paraprofessional status according to 10A NCAC 27G and who have the knowledge, skills and abilities required by the population and age to be served may deliver Day Treatment services, under the supervision of a CCAS or CCS.

Service Type/Setting

This is a day/night service that shall be available a minimum of three hours a day during all days of operation. Must be in operation a minimum of two days per week.

This is a facility based service and is provided in a licensed and structured program setting appropriate for the developmental age of children and adolescents. At least 50% of the treatment services shall be provided in the on-site licensed setting.

Utilization Management

In order for day treatment service to be reimbursable, all of the following shall apply:

1. The child shall meet clinical necessity criteria for Day Treatment services as outlined below.
2. The service shall be reflected in the child's Person Centered Plan.

Authorization by the statewide vendor or the LME is required. Utilization review shall be conducted 30 days after the first date of service or on the first business day thereafter. Subsequently, Utilization Review shall be provided a minimum of 30 days or more frequently as needed. All utilization review activity shall be documented in the Provider's Service Plan.

If it is a Medicaid covered service, utilization management will be done by the state vendor or the DHHS approved LME contracted with the Medicaid agency. If it is a non-covered Medicaid service or non-Medicaid client, then the utilization review will be done by the LME.

Entrance Criteria

A. Shall have an Axis I or II diagnosis based on DSM IV-TR criteria.

AND

B. The client's treatment needs meets Level of Care criteria.

AND

C. The client is experiencing symptoms/behaviors related to his/her diagnosis that severely impair functional ability in academic, social, vocational, community, or family domains.

AND

D. Any one of the following shall apply:

   1. The child is living in a family setting and is at risk of being removed from that setting for reasons related to items 1-3, immediately above.

OR

   2. The child is at risk of or has already experienced significant preschool/school disruption (multiple suspensions, long term suspensions, expulsion, impaired or destructive peer relationships, etc.) for reasons related to items 1 through 3 above.

AND

E. Any of the following apply**:**

1. Client requires a Day Treatment to acquire any of the following: improved coping skills and strategies, disability management strategies, or strategies for managing behaviors associated with functional impairments.

OR

2. The child is 3 to 5 years of age with atypical social and emotional development and manifest behaviors of a diagnosable mental disorder without therapeutic intervention.

Continued Stay Criteria

Any one of the following apply:

A. Recipient has achieved initial PCP/Child and Family Plan goals and additional goals are indicated.

B. Recipient is making satisfactory progress toward meeting goals but goals have not yet been fully met.

C. Recipient is making some progress, but the PCP/Child and Family Plan (specific interventions) need to be modified so that greater gains can be achieved.

D. Recipient is not making progress; the PCP/Child and Family Plan must be modified to identify more effective interventions.

E. Recipient is regressing; the PCP/Child and Family Plan must be modified to identify more effective interventions.

AND

Utilization review shall be conducted 30 days after the first date of service or on the first business day thereafter. Subsequently, Utilization Review shall be provided every 30 days thereafter or more frequently as needed. All utilization review activity shall be documented in the Provider's Service Plan.

Discharge Criteria

Any of the following apply:

A. Consumer has achieved goals, discharge and transition plan to a lower level of care is indicated.

B. Consumer is not making progress, or is regressing and all realistic treatment options with this modality have been exhausted indicating a need for more intensive services.

C. Consumer and family determine this service is no longer needed in consultation with a QP.

Note: Any denial, reduction, suspension, or termination of service requires notification to the consumer and/or legal guardian about their appeal rights.

Expected Outcomes

- Child is able to remain in their home.
- Child is making satisfactory school progress and with interactions with staff and peers.
- Child will acquire behavioral/coping skills/symptom and behavior management needed to enhance functioning and resiliency.
- Child will acquire strategies to minimize the ongoing impact of mental health or substance related disabilities on their level of functioning and quality of life.
- Child will be reintegrated into school settings or transition into employment.

Documentation Requirements

Minimum documentation is a daily service note that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, describes the provider's intervention, the time spent performing the intervention, the effectiveness of interventions and the signature of the staff providing the service.

The PCP shall include a Crisis Plan and a Transition Plan. The service record shall reflect outcomes sustained and progress toward implementing the Transition Plan. These shall be noted, minimally, at Utilization Review intervals and/or service team meetings. Transition planning should be coordinated through the Child and Family Team and with the local system of care (as necessary) including the local education agency, other involved individuals and community providers such as social services, juvenile justice and vocational rehabilitation.

Service Exclusions

Day Treatment can only be provided by one Day Treatment provider at a time.

- Educational skills that are usually taught in primary or secondary school settings; e.g., reading, math, writing, etc. are not reimbursable. Such skills and educational advancement should be coordinated with and provided by the local education agency.
- This service may not be provided in the consumer's place of residence.
- This service is only to be provided in a community based setting.
- This service may not be provided during the same authorization period with the following services: Residential treatment, psychiatric residential treatment facility (PRTF), inpatient hospital setting, Substance Abuse Intensive Out-patient Services, SA residential facilities, Multisystemic Therapy, Community Support (except as noted below), or Intensive In-Home Services.
- Community support services can be billed for a maximum of 8 units per month in accordance with the person centered plan for the individuals who are receiving day treatment services for the purpose of facilitating transition to the service, admission to the service, meeting with the person as soon as possible upon admission, providing coordination during the provision of service, ensuring that the service provider works directly with the CS professional and discharge planning.

Note: For recipients under the age of 21, additional products, services, or procedures may be requested even if they do not appear in the N.C. State Plan or when coverage is limited to those over 21 years of age. Service limitations on scope, amount, or frequency described in the coverage policy may not apply if the product, service, or procedure is medically necessary.

Partial Hospitalization

Partial Hospitalization is a short-term service for acutely mentally ill children or adults, which provides a broad range of intensive therapeutic approaches which may include: group activities/therapy, individual therapy, recreational therapy, community living skills/training, increases the individual's ability to relate to others and to function appropriately, coping skills, medical services. This service is designed to prevent hospitalization or to serve as an interim step for those leaving an inpatient facility. A physician shall participate in diagnosis, treatment planning, and admission/discharge decisions. Physician involvement shall be one factor that distinguishes Partial Hospitalization from Day Treatment Services.

Therapeutic Relationship and Interventions
This service is designed to offer face-to-face therapeutic interventions to provide support and guidance in preventing, overcoming, or managing identified needs on the service plan to aid with improving the client's level of functioning in all domains, increasing coping abilities or skills, or sustaining the achieved level of functioning.

Structure of Daily Living
This service offers a variety of structured therapeutic activities including medication monitoring designed to support a client remaining in the community that are provided under the direction of a physician, although the program does not have to be hospital based. Other identified providers shall carry out the identified individual or group interventions (under the direction of the physician). This service offers support and structure to assist the individual client with coping and functioning on a day-to-day basis to prevent hospitalization or to step down into a lower level of care from inpatient setting.

Cognitive and Behavioral Skill Acquisition
This service includes interventions that address functional deficits associated with affective or cognitive problems and/or the client's diagnostic conditions. This may include training in community living, and specific coping skills, and medication management. This assistance allows clients to develop their strengths and establish peer and community relationships.

Service Type
This is day/night service that shall be provided a minimum of (3) three hours per day, (5) five days per week, and (12) twelve months per year. Service standards and licensure requirements are outlined in10A NCAC 27G.1100. If it is a Medicaid covered service, utilization management will be done by the state vendor or the DHHS approved LME contracted with the Medicaid agency. If it is a non-covered Medicaid service or non-Medicaid client, then the utilization review will be done by the LME.

Resiliency/Environmental Intervention
This service assists the client in transitioning from one service to another (an inpatient setting to a community-based service) or preventing hospitalization. This service provides a broad array of intensive approaches, which may include group and individual activities.

Service Delivery Setting
This service is provided in a licensed facility that offers a structured, therapeutic program under the direction of a physician that may or may not be hospital based.

Medical Necessity

Must have Axis I or II diagnosis

AND

Level of Care Criteria, Level C/NCSNAP

AND

The consumer is experiencing difficulties in at least one of the following areas:

A. Functional impairment, crisis intervention/diversion/aftercare needs, and/or at risk for placement outside the natural home setting,

AND

B. The consumer's level of functioning has not been restored or improved and may indicate a need for clinical interventions in a natural setting if any on of the following apply:

1. Being unable to remain in family or community setting due to symptoms associated with diagnosis, therefore being at risk for out of home placement, hospitalizations, and/or institutionalization.
2. Presenting with intensive, verbal and limited physical aggression due to symptoms associated with diagnosis, which are sufficient to create functional problems in a community setting.
3. Being at risk of exclusion from services, placement or significant community support system as a result of functional behavioral problems associated with diagnosis.
4. Requires a structured setting to monitor mental stability and symptomology, and foster successful integration into the community through individualized interventions and activities.
5. Service is a part of an aftercare planning process (time limited or transitioning) and is required to avoid returning to a higher, or more restrictive level of service.

Service Order Requirement

A Physician, PhD, Psychiatric Nurse Practitioners, Psychiatric Clinical Nurse Specialist within their scope of practice can order this service. The service must be ordered prior to or on the day the service is initiated.

Continuation/Utilization Review Criteria

The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the consumer's service plan or the consumer continues to be at risk for relapse based on history or the tenuous nature of the functional gains or any one of the following apply:

A. Consumer has achieved initial service plan goals and additional goals are indicated,

B. Consumer is making satisfactory progress toward meeting goals.

C. Consumer is making some progress, but the service plan (specific interventions) need to be modified so that greater gains which are consistent with the consumer's premorbid level of functioning are possible or can be achieved.

D. Consumer is not making progress; the service plan must be modified to identify more effective interventions.

E. Consumer is regressing; the service plan must be modified to identify more effective interventions.

Discharge Criteria
Consumer's level of functioning has improved with respect to the goals outlined in the service plan, inclusive of a transition plan to step down, or no longer benefits, or has the ability to function at this level of care and any of the following apply:

A. Consumer has achieved goals, discharged to a lower level of care is indicated.

B. Consumer is not making progress, or is regressing and all realistic treatment options with this modality have been exhausted.

*__Note:__ Any denial, reduction, suspension or termination of service requires notification to the recipient and/or legal guardian about their appeal rights.

Service Maintenance Criteria
If the consumer is functioning effectively with this service and discharge would otherwise be indicated, PH should be maintained when it can be reasonably anticipated that regression is likely to occur if the service is withdrawn. The decision should be based on any one of the following:

A. Past history of regression in the absence of PH is documented in the consumer record,

OR

B. The presence of a DSM-IV diagnosis that would necessitate a disability management approach. In the event, there is epidemiological sound expectations that symptoms will persist and that on Going treatment interventions are needed to sustain functional gains.

*__Note:__ Any denial, reduction, suspension or termination of service requires notification to the recipient and/or legal guardian about their appeal rights.

Provider Requirement and Supervision
All services in the partial hospital are provided by a team, which may have the following configuration: social workers, psychologists, therapists, case managers, or other MH/SA paraprofessional staff. The partial hospital milieu is directed under the supervision of a physician. Staffing requirements are outlined in 10A NCAC 27G .1102.

Documentation Requirements
Minimum documentation is a weekly service note that includes the purpose of contact, describes the provider's interventions, and the effectiveness of the interventions.

Professional Treatment Services in Facility-Based Crisis Program

This service provides an alternative to hospitalization for adults who have a mental illness or substance abuse disorder. This is a 24-hour residential facility with 16 beds or less that provides support and crisis services in a community setting. This can be provided in a non-hospital setting for recipients in crisis who need short-term intensive evaluation, treatment intervention or behavioral management to stabilize acute or crisis situations.

Therapeutic Relationship and Interventions
This service offers therapeutic interventions designed to support a recipient remaining in the community and alleviate acute or crisis situations that are provided under the direction of a physician, although the program does not have to be hospital based. Interventions are implemented by other staff under the direction of the physician. These supportive interventions assist the recipient with coping and functioning on a day-to-day basis to prevent hospitalization.

Structure of Daily Living
This service is an intensified short-term, medically supervised service that is provided in certain 24-hour service sites. The objectives of the service include assessment and evaluation of the condition(s) that have resulted in acute psychiatric symptoms, disruptive or dangerous behaviors, or intoxication from alcohol or drugs; to implement intensive treatment, behavioral management interventions, or detoxification protocols; to stabilize the immediate problems that have resulted in the need for crisis intervention or detoxification; to ensure the safety of the individual by closely monitoring his/her medical condition and response to the treatment protocol; and to arrange for linkage to services that will provide further treatment and/or rehabilitation upon discharge from the Facility Based Crisis Service.

Cognitive and Behavioral Skill Acquisition
This service is designed to provide support and treatment in preventing, overcoming, or managing the identified crisis or acute situations on the service plan to assist with improving the recipient's level of functioning in all documented domains, increasing coping abilities or skills, or sustaining the achieved level of functioning.

Service Type
This is a 24-hour service that is offered seven (7) days a week.

Resiliency/Environmental Intervention
This service assists the recipient with remaining in the community and receiving treatment interventions at an intensive level without the structure of an inpatient setting. This structured program assesses, monitors, and stabilizes acute symptoms twenty-four (24) hours a day.

Service Delivery Setting
This service can be provided in a licensed facility that meets 10A NCAC 27G.5000 licensure standards.

Medical Necessity
The recipient is eligible for this service when:

A. There is an Axis I or II diagnosis present or the person has a condition that may be defined as a developmental disability as defined in GS 122C-3 (12a)

AND

B. Level of Care Criteria, Level D/NC-SNAP (NC Supports/Needs Assessment Profile)/ASAM (American Society of Addiction Medicine)

AND

C. The recipient is experiencing difficulties in at least one of the following areas:

1. functional impairment,
2. crisis intervention/diversion/after-care needs, and/or
3. at risk for placement outside of the natural home setting.

AND

D. The recipient's level of functioning has not been restored or improved and may indicate a need for clinical interventions in a natural setting if any one of the following apply:

1. Unable to remain in family or community setting due to symptoms associated with diagnosis, therefore being at risk for out of home placement, hospitalization, and/or institutionalization.
2. Intensive, verbal and limited physical aggression due to symptoms associated with diagnosis, which are sufficient to create functional problems in a community setting.
3. At risk of exclusion from services, placement or significant community support systems as a result of functional behavioral problems associated with diagnosis.

Service Order Requirement
Service must be ordered by a primary care physician, psychiatrist or a licensed psychologist. All service orders must be made prior to or on the day service is initiated.

Continuation/Utilization Review
The desired outcome or level of functioning has not been restored, improved or sustained over the time frame outlined in the recipient's service plan or the recipient continues to be at risk for relapse based on history or the tenuous nature of the functional gains or any one of the following apply:

A. Recipient has achieved initial service plan goals and additional goals are indicated.

B. Recipient is making satisfactory progress toward meeting goals.

C. Recipient is making some progress, but the service plan (specific interventions) need to be modified so that greater gains, which are consistent with the recipient's premorbid level of functioning, are possible or can be achieved.

D. Recipient is not making progress; the service plan must be modified to identify more effective interventions.

E. Recipient is regressing; the service plan must be modified to identify more effective interventions.

AND

Utilization review by the state vendor or the DHHS approved LME contracted with Medicaid must be conducted after the first 7 days and is so documented in the service record. This is a short-term service that cannot be provided for more than 30 days in a 12 month period.

Discharge Criteria
Recipient's level of functioning has improved with respect to the goals outlined in the service plan, inclusive of a transition plan to step-down or no longer benefits or has the ability to function at this level of care and any of the following apply:

A. Recipient has achieved goals, discharge to a lower level of care is indicated.

B. Recipient is not making progress or is regressing and all realistic treatment options with this modality have been exhausted.

*__Note:__ Any denial, reduction, suspension or termination of service requires notification to the recipient and/or legal guardian about their appeal rights.

Service Maintenance Criteria
If the recipient is functioning effectively with this service and discharge would otherwise be indicated, Facility-based crisis service should be maintained when it can be reasonably anticipated that regression is likely to occur if the service is withdrawn. The decision should be based on any one of the following:

A. Past history of regression in the absence of facility based crisis service is documented in the service record

OR

B. In the event there are epidemiologically sound expectations that symptoms will persist and that ongoing treatment interventions are needed to sustain f functional gains, the nature of the recipient's DSM-IV diagnosis necessitates a disability management approach.

*__Note:__ Any denial, reduction, suspension or termination of service requires notification to the recipient and/or legal guardian about their appeal rights.

Provider Requirement and Supervision
This is a 24-hour service that is offered seven days a week, with a staff to recipient ratio that ensures the health and safety of clients served in the community and compliance with 10NCAC 14R.0104 Seclusion, Restraint and Isolation Time Out. At no time will staff to recipient ratio be less than 1:6 for adult mental health recipients and 1:9 for adult substance abuse recipients.

Documentation Requirements
Minimum documentation is a daily service note per shift.

SUBSTANCE ABUSE SERVICES
Medicaid Billable Service

Diagnostic Assessment

See Diagnostic/Assessment (MH/DD/SA) service.

Mobile Crisis Management

See Mobile Crisis Management (MH/DD/SA) service.

Community Support – Adult

See Community Support – Adult (MH/SA).

Community Support – Child/Adolescents

See Community Support – Child/Adolescents (MH/SA).

Community Support Team – Adult

See Community Support Team —Adult (MH/SA).

Substance Abuse Intensive Outpatient Program
Medicaid Billable Service

Level II.1 Intensive Outpatient Services ASAM Patient Placement Criteria

Service Definition and Required Components

SA Intensive Outpatient Program (SAIOP) means structured individual and group addiction activities and services that are provided at an outpatient program designed to assist adult and adolescent consumers to begin recovery and learn skills for recovery maintenance. The program is offered at least three (3) hours per day at least three (3) days per week with no more than two consecutive days between offered services, and distinguishes between those individuals needing no more than 19 hours per week of structured services per week (ASAM Level II.1). The recipient must be in attendance for a minimum of three (3) hours per day in order to bill this service. SAIOP services shall include a structured program consisting of, but not limited to, the following services:

1. Individual counseling and support;
2. Group counseling and support;
3. Family counseling, training or support;
4. Biochemical assays to identify recent drug use (e.g. urine drug screens);
5. Strategies for relapse prevention to include community and social support systems in treatment;
6. Life skills;
7. Crisis contingency planning;
8. Disease Management; and
9. Treatment support activities that have been adapted or specifically designed for persons with physical disabilities, or persons with co-occurring disorders of mental illness and substance abuse/dependence or mental retardation/developmental disability and substance abuse/dependence.

SAIOP can be designed for homogenous groups of recipients e.g., pregnant women, and women and their children; individuals with co-occurring MH/SA disorders; individuals with HIV; or individuals with similar cognitive levels of functioning. Group counseling shall be provided each day SAIOP services are offered. SAIOP includes case management to arrange, link or integrate multiple services as well as assessment and reassessment of the recipient's need for services. SAIOP services also informs the recipient about benefits, community resources, and services; assists the recipient in accessing benefits and services; arranges for the recipient to receive benefits and services; and monitors the provision of services. Consumers may be residents of their own home, a substitute home, or a group care setting; however, the SAIOP must be provided in a setting separate from the consumer's residence. The program is provided over a period of several weeks or months.

A service order for SAIOP must be completed by a physician, licensed psychologist, physician's assistant or nurse practitioner according to their scope of practice prior to or on the day that the services are to be provided.

Provider Requirements

SAIOP must be delivered by practitioners employed by a substance abuse provider organization that meet the provider qualification policies, procedures, and standards established by DMH and the requirements of 10A NCAC 27G These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrate that they meet these standards by being endorsed by LME. Within three years of enrollment as a provider, the organization must have achieved national accreditation. The organization must be established as a legally recognized entity in the United States and qualified/registered to do business as a corporate entity in the State of North Carolina.

Organizations that provide SAIOP must provide "first responder" crisis response on a 24/1/365 basis to recipients who are receiving this service

Staffing Requirements

Persons who meet the requirements specified for CCS, CCAS, and CSAC under Article 5C may deliver SAIOP. The program must be under the clinical supervision of a CCS or a CCAS who is on site a minimum of 50% of the hours the service is in operation. Services may also be provided by staff who meet the requirements specified for QP or AP status for Substance Abuse according to 10A NCAC, under the supervision of a CCAS or CCS. The maximum face-to-face staff-to-client ratio is not more than 12 adult consumers to 1 QP based on an average daily attendance. The ratio for adolescents will be 1:6. Paraprofessional level providers who meet the requirements for Paraprofessional status according to 10A NCAC 27G and who have the knowledge, skills, and abilities required for the population and age to be services may deliver SAIOP, under the supervision of a CCAS or CCS. Paraprofessional level providers may not provide services in lieu of on-site service provision by a qualified professional, CCAS, CCS, or CSAC.

Service Type/Setting

Facility licensed under 10A NCAC 27G.3700.

Program Requirements

See Service Definition and Required Components.

Utilization Management

Authorization by the statewide vendor or the DHHS approved LME contracted with the Medicaid agency is required. The amount, duration, and frequency of SAIOP Service must be included in an individual's authorized Person Centered Plan. Services may not be delivered less frequently than the structured program set forth in the service description above. Initial authorization for services will not exceed a duration of 12 weeks. Under exceptional circumstances, one additional reauthorization up to 2 weeks can be approved. This service is billed with a minimum of three (3) hours per day as an event.

Entrance Criteria

The recipient is eligible for this service when:

A. There is an Axis I substance abuse disorder present;

AND

B. Level of Care Criteria, level II.1 NC Modified A/ASAM

Continued Stay Criteria

The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the recipient's Person Centered Plan or the recipient continues to be at risk for relapse based on history or the tenuous nature of the functional gains or any one of the following apply:

A. Recipient has achieved positive life outcomes that support stable and ongoing recovery, and additional goals are indicated.

B. Recipient is making satisfactory progress toward meeting goals.

C. Recipient is making some progress, but the Person Centered Plan (specific interventions) needs to be modified so that greater gains, which are consistent with the recipient's premorbid level of functioning, are possible or can be achieved.

D. Recipient is not making progress; the Person Centered Plan must be modified to identify more effective interventions

E. Recipient is regressing; the Person Centered Plan must be modified to identify more effective interventions.

Expected Outcomes

The expected outcome of SAIOP is abstinence. Secondary outcomes (i.e., in *abstinent* patients) include: sustained improvement in health and psychosocial functioning, reduction in any psychiatric symptoms (if present), reduction in public health and/or safety concerns, and a reduction in the risk of relapse as evidenced by improvement in empirically supported modifiable relapse risk factors.

Documentation Requirements

Minimum standard is a daily full service note for each day of SAIOP that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, describes the provider's interventions, the time spent performing the intervention, the effectiveness of interventions, and the signature and credentials of the staff providing the service. A documented discharge plan will be discussed with the recipient and included in the record

Discharge Criteria

Recipient's level of functioning has improved with respect to the goals outlined in the Person Centered Plan, inclusive of a transition plan to step down, or no longer benefits, or has the ability to function at this level of care and any of the following apply:

1. Recipient has achieved positive life outcomes that support stable and ongoing recovery.
2. Recipient is not making progress, or is regressing and all realistic treatment options have been exhausted indicating a need for more intensive services.
3. Recipient no longer wishes to receive SAIOP services.

Service Exclusions/Limitations

SAIOP cannot be billed during the same authorization as SA Comprehensive Outpatient Treatment, all detoxification services levels, Non-Medical Community Residential Treatment or Medically Monitored Community Residential Treatment.

Service Limitations: Community support services can be billed for a maximum of 8 units per month in accordance with the person centered plan for individuals who are receiving SAIOP services for the purpose of facilitating transition to the service, admission to the service, meeting with the person as soon as possible upon admission, providing coordination during the provision of service, ensuring that the service provider works directly with the CS professional and discharge planning.

Note: For recipients under the age of 21, additional products, services, or procedures may be requested even if they do not appear in the N.C. State Plan or when coverage is limited to those over 21 years of age. Service limitations on scope, amount, or frequency described in the coverage policy may not apply if the product, service, or procedure is medically necessary.

Substance Abuse Comprehensive Outpatient Treatment Program Medicaid Billable Service

Level II.5 Partial Hospitalization ASAM Patient Placement Criteria

Service Definition and Required Components

SA Comprehensive Outpatient Treatment (SACOT) Program means a periodic service that is a time-limited, multi-faceted approach treatment service for adults who require structure and support to achieve and sustain recovery. SACOT Program is a service emphasizing reduction in use and abuse of substances and/or continued abstinence, the negative consequences of substance abuse, development of social support network and necessary lifestyle changes, educational skills, vocational skills leading to work activity by reducing substance abuse as a barrier to employment, social and interpersonal skills, improved family functioning, the understanding of addictive disease, and the continued commitment to a recovery and maintenance program. These services are provided during day and evening hours to enable individuals to maintain residence in their community, continue to work or go to school, and to be a part of their family life. The following types of services are included in the SACOT Program:

1. Individual counseling and support;
2. Group counseling and support;
3. Family counseling, training or support;
4. Biochemical assays to identify recent drug use (e.g., urine drug screens);
5. Strategies for relapse prevention to include community and social support systems in treatment;
6. Life skills;
7. Crisis contingency planning;
8. Disease management; and
9. Treatment support activities that have been adapted or specifically designed for persons with physical disabilities or persons with co-occurring disorders of mental illness and substance abuse/dependence or mental retardation/developmental disability and substance abuse/dependence.

SACOT programs can be designed for homogenous groups of recipients e.g., individuals being detoxed on an outpatient basis; individuals with chronic relapse issues; pregnant women, and women and their children; individuals with co-occurring MH/SA disorders; individuals with HIV; or individuals with similar cognitive levels of functioning. SACOT includes case management to arrange, link or integrate multiple services as well as assessment and reassessment of the recipient's need for services. SACOT services also inform the recipient about benefits, community resources, and services; assists the recipient in accessing benefits and services; arranges for the recipient to receive benefits and services; and monitors the provision of services. Consumers may be residents of their own home, a substitute home, or a group care setting; however, the SACOT Program must be provided in a setting separate from the consumer's residence.

A service order for SACOT must be completed prior to or on the day that the services are to be provided by a physician, licensed psychologist, physician's assistant or nurse practitioner according to their scope of practice.

This service must operate at least 20 hours per week and offer a minimum of 4 hours of scheduled services per day, with availability at least 5 days per week with no more than 2 consecutive days without services available. The recipient must be in attendance for a minimum of four (4) hours per day in order to this for this service. Group counseling services must be offered each day the program operates. Services must be available during both day and evening hours. A SACOT Program may have variable lengths of stay and reduce each individual's frequency of attendance as recovery becomes established and the individual can resume more and more usual life obligations. The program conducts random drug screening and uses the results of these tests as part of a comprehensive assessment of participants' progress toward goals and for Person Centered Planning.

Provider Requirements

SACOT Program must be delivered by practitioners employed by a substance abuse provider organization that meet the provider qualification policies, procedures, and standards established by DMH and the requirements of 10A NCAC 27G These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrate that they meet these standards by being endorsed by LME. Within three years of enrollment as a provider, the organization must have achieved national accreditation. The organization must be established as a legally recognized entity in the United States and qualified/registered to do business as a corporate entity in the State of North Carolina.

Organizations that provide SACOT must provide "first responder" crisis response on a 24/7/365 basis to recipients who are receiving this service.

Staffing Requirements

Persons who meet the requirements specified for CCS, CCAS, and CSAC under Article 5C may deliver SACOT Program. The program must be under the clinical supervision of a CCAS or CCS who is on site a minimum of 90% of the hours the service is in operation. – Clinical services may also be provided by staff who meet the requirements specified for QP or AP status for Substance Abuse according to 10A NCAC 27G.0104, under the supervision of a CCS. The maximum face-to-face staff-to-client ratio is not more than 10 adult consumers to 1 QP based on an average daily attendance. Paraprofessional level providers who meet the requirements for Paraprofessional status according to 10A NCAC 27G.0104 and who have the knowledge, skills and abilities required by the population and age to be served may deliver SACOT Program, under the supervision of CCAS, CSAC or CCS. Paraprofessional level providers may not provide services in lieu of on-site service provision to recipients by a qualified CCS, CCAS or CSAC.

Consultation Services

Recipients must have ready access to psychiatric assessment and treatment services when warranted by the presence of symptoms indicating a co-occurring non-substance related Axis I or Axis II disorder (e.g. major depression, schizophrenia, borderline personality disorder). These services shall be delivered by a psychiatrists who meet requirements as specified in NCAC 27G.0104. The providers shall be familiar with the SACOT Program treatment plan for each recipient seen in consultation, shall have access to SACOT Program treatment records for the recipient, and shall be able to consult by phone or in person with the CCS, CCAS or CSAC providing SACOT Program services.

Service Type/Setting

Facility licensed in accordance with TBD.

Program Requirements

See Service Definition and Required Components.

Utilization Management

Authorization by the statewide vendor or the LME if approved by DHHS is required. The amount, duration, and frequency of the services must be included in an individual's authorized Person Centered Plan. Services may not be recommended to occur less frequently than the structured program's requirements set forth in the service description above. Utilization review will occur every 30 days. This service is billed with a minimum of four (4) hours per day ~~as an event.~~ billed in hourly increments

If it is a Medicaid covered service, utilization management will be done by the state vendor or the DHHS approved LME contracted with the Medicaid agency. If it is a non-covered Medicaid service or non-Medicaid client, then the utilization review will be done by the LME.

Entrance Criteria

The recipient is eligible for this service when:

A. There is an Axis I diagnosis of a Substance Abuse disorder diagnosis.

AND

B. Level of Care Criteria Level II.5 NC Modified A/ASAM

Continued Stay Criteria

The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the recipient's Person Centered Plan or the recipient continues to be at risk for relapse based on history or the tenuous nature of the functional gains or any one of the following apply:

1. Recipient has achieved initial Person Centered Plan goals and continued service at this level is needed to meet additional goals.
2. Recipient is making satisfactory progress toward meeting goals.
3. Recipient is making some progress, but the PCP (specific interventions) needs to be modified so that greater gains, which are consistent with the recipient's premorbid level of functioning, are possible or can be achieved.
4. Recipient is not making progress; the Person Centered Plan must be modified to identify more effective interventions.
5. Recipient is regressing; the Person Centered Plan must be modified to identify more effective interventions.

AND

Utilization review must be conducted every 30 days and is so documented in the Person Centered Plan and the service record.

Discharge Criteria

Recipient's level of functioning has improved with respect to the goals outlined in the Person Centered Plan, inclusive of a transition plan to step down, or no longer benefits, or has the ability to function at this level of care and any of the following apply:

1. Recipient has achieved positive life outcomes that supports stable and ongoing recovery.
2. Recipient is not making progress, or is regressing and all realistic treatment options have been exhausted indicating a need for more intensive services.
3. Recipient/family no longer wishes to receive SACOT services.

Expected Outcomes

The expected outcome is abstinence. Secondary outcomes (i.e., in *abstinent* patients) include: sustained improvement in health and psychosocial functioning, reduction in any psychiatric symptoms (if present), reduction in public health and/or safety concerns, and a reduction in the risk of relapse as evidenced by improvement in empirically-supported modifiable relapse risk factors. For individuals with co-occurring MH/SA disorders, improved functioning is the expected outcome.

Documentation Requirements

Minimum standard is a daily full service note for each day of SACOT that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, describes the provider's interventions, the time spent performing the intervention, the effectiveness of interventions, and the signature and credentials of the staff providing the service. A documented discharge plan will be discussed with the recipient and included in the record

Service Exclusions/Limitations

SACOT cannot be billed during the same authorization as SA Intensive Outpatient Program, all detoxification services levels (with the exception of Ambulatory Detoxification) or Non-Medical Community Residential Treatment or Medically Monitored Community Residential Treatment.

Service Limitation: Community Support services can be billed for a maximum of 8 units per month in accordance with the person centered plan for individuals who are receiving SACOT services for the purpose of facilitating transition to the service, admission to the service, meeting with the person as soon as possible upon admission, providing coordination during the provision of service, ensuring that the service provider works directly with the CS professional and discharge planning.

Note: For recipients under the age of 21, additional products, services, or procedures may be requested even if they do not appear in the N.C. State Plan or when coverage is limited to those over 21 years of age. Service limitations on scope, amount, or frequency described in the coverage policy may not apply if the product, service, or procedure is medically necessary.

Substance Abuse Non-Medical Community Residential Treatment Medicaid Billable Service (When Furnished in a Facility that Does Not Exceed 16 Beds and is Not an Institution for Mental Diseases for Adults) (Room and Board is Not Included)

Level III.5 Clinically Managed High-Intensity Residential Treatment

NC Modified ASAM Patient Placement Criteria

Service Definition and Required Components

Non-medical Community Residential Treatment is a 24-hour residential recovery program professionally supervised residential facility that provides trained staff who work intensively with adults with substance abuse disorders who provide or have the potential to provide primary care for their minor children. This is a rehabilitation facility, without twenty-four hour per day medical nursing/monitoring, where a planned program of professionally directed evaluation, care and treatment for the restoration of functioning for persons with an addiction disorder.

These programs shall include assessment/referral, individual and group therapy, family therapy, recovery skills training, disease management, symptom monitoring, monitoring medications and self management of symptoms, aftercare, follow-up and access to preventive and primary health care including psychiatric care. The facility may utilize services from another facility providing psychiatric or medical services. Services shall promote development of a social network supportive of recovery, enhance the understanding of addiction, promote successful involvement in regular productive activity (such as school or work), enhance personal responsibility and promote successful reintegration into community living. Services shall be designed to provide a safe and healthy environment for consumers and their children.

Program staff will arrange, link or integrate multiple services as well as assessment and reassessment of the recipient's need for services. Program staff will inform the recipient about benefits, community resources, and services; assist the recipient in accessing benefits and services; arrange for the recipient to receive benefits and services; and monitor the provision of services.

For programs providing services to individuals with their children in residence and/or pregnant women: Each adult shall also receive in accordance with their Person-Centered Plan: training in therapeutic parenting skills, basic independent living skills, child supervision, one-on-one interventions with the community to develop interpersonal and community coping skills, including adaptation to school and work environments and therapeutic mentoring. In addition, their children shall receive services in accordance with 10A NCAC 27G.4100.
A service order for NMCRT must be completed by a physician, licensed psychologist, physician's assistant or nurse practitioner according to their scope of practice prior to or on the day that the services are to be provided.

Provider Requirements

NMCRT must be delivered by practitioners employed by a substance abuse provider organization that meet the provider qualification policies, procedures, and standards established by DMH and the requirements of 10A NCAC 27G These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrate that they meet these standards by being endorsed by LME. Within three years of enrollment as a provider, the organization must have achieved national accreditation. The organization must be established as a legally recognized entity in the United States and qualified/registered to do business as a corporate entity in the State of North Carolina.

Organizations that provide NMCRT must provide "first responder" crisis response on a 24/7/365 basis to recipients receiving this service.

Staffing Requirements

Persons who meet the requirements specified for CCS, CCAS, and CSAC under Article 5C may deliver NMCRT. Programs providing services to adolescents must have experience working with the population. The program must be under the clinical supervision of a CCAS or CCS who is on site a minimum of 8 hours per day when the service is in operation and available by phone 24 hours a day. Services may also be provided by staff who meet the requirements specified for QP or AP status for Substance Abuse according to 10A NCAC 27G.0104, under the supervision of a CCAS or CCS. Paraprofessional level providers who meet the requirements for Paraprofessional status according to 10A NCAC 27G.0104 and who have the knowledge, skills and abilities required by the population and age to be served may deliver NMCRT, under the supervision of a CCAS or CCS. Paraprofessional level providers may not provide services in lieu of on-site service provision by a qualified professional, CCS, CCAS or CSAC.

Service Type/Setting

Programs for pregnant women and/or individuals with children in residence shall be licensed under 10A NCAC 14V.4100 for residential recovery programs.

Program Requirements

See Service Definition and Required Components and 10A NCAC 27G.4100 for residential recovery programs.

See Service Definition and Required Components and 10A NCAC 27G.3400 for adolescent programs.

Utilization Management

Authorization by the statewide vendor or the LME approved by DHHS is required. Service must be included in the individual's Person Centered Plan. Initial authorization for parents with children program services must not exceed 30 days. Reauthorization for these programs will occur within a minimum of 90 days thereafter by the statewide vendor or LME.

If it is a Medicaid covered service, utilization management will be done by the state vendor or the DHHS approved LME contracted with the Medicaid agency. If it is a non-covered Medicaid service or non-Medicaid client, then the utilization review will be done by the LME.

Entrance Criteria

The recipient is eligible for this service when:

A. There is an Axis I diagnosis of a substance abuse disorder

AND

B. Level of Care Criteria Level III.5 NC Modified A/ASAM

Continued Stay Criteria

The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the recipient's Person Centered Plan or the recipient continues to be at risk for relapse based on history or the tenuous nature of the functional gains or any one of the following apply:

- Recipient has achieved initial person centered plan goals and requires this service in order to meet additional goals.
- Recipient is making satisfactory progress toward meeting goals.
- Recipient is making some progress, but the Person Centered Plan (specific interventions) needs to be modified so that greater gains, which are consistent with the recipient's pre-morbid level of functioning, are possible or can be achieved.
- Recipient is not making progress; the Person Centered Plan must be modified to identify more effective interventions.
- Recipient is regressing; the Person Centered Plan must be modified to identify more effective interventions.

AND

Utilization review must be conducted every 90 days (after the initial 30 day UR) for the parents with children programs and is so documented in the Person Centered Plan and the service record. Utilization review must be conducted every 30 days for the adolescent programs and is so documented in the Person Centered Plan and the service record.

Discharge Criteria

Recipient's level of functioning has improved with respect to the goals outlined in the Person Centered Plan, inclusive of a transition plan to step down, or no longer benefits, or has the ability to function at this level of care and any of the following apply:

1. Recipient has achieved positive life outcomes that supports stable and ongoing recovery (and parenting skills, if applicable).
2. Recipient is not making progress, or is regressing and all realistic treatment options have been exhausted indicating a need for more intensive services.
3. Recipient/family no longer wishes to receive NMCRT services.

Expected Outcomes

The expected outcome is abstinence. Secondary outcomes (i.e., in *abstinent* patients) include: sustained improvement in health and psychosocial functioning, reduction in any psychiatric symptoms (if present), reduction in public health and/or safety concerns, and a reduction in the risk of relapse as evidenced by improvement in–empirically-supported modifiable relapse risk factors. Additionally, for Residential Recovery Programs, improved parenting is an expected outcome.

Documentation Requirements

Minimum standard is a full daily note that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, describes the provider's interventions, the time spent performing the intervention, the effectiveness of interventions, and the signature and credentials of the staff providing the service. Residential Recovery Programs for women and children shall also provide documentation of all services provided to the children in the program. Goals for parent-child interaction shall be established and progress towards meeting these goals shall be documented in the parent's service record. A documented discharge plan discussed with the recipient is included in the record.

Service Exclusions/Limitations

Non-Medical Community Residential Treatment cannot be billed the same day as any other MH/SA services except group living moderate. This is a short-term service that can only be billed for 30 days in a 12 month period

Service Limitations: Community support services can be billed for a maximum of 8 units per month in accordance with the person centered plan for individuals who are receiving Non-Medical Community Residential Treatment Services for the purpose of facilitating transition to the service, admission to the service, meeting with the person as soon as possible upon admission, providing coordination during the provision of service, ensuring that the service provider works directly with the CS professional and discharge planning

Note: For recipients under the age of 21, additional products, services, or procedures may be requested even if they do not appear in the N.C. State Plan or when coverage is limited to those over 21 years of age. Service limitations on scope, amount, or frequency described in the coverage policy may not apply if the product, service, or procedure is medically necessary.

Substance Abuse Medically Monitored Community Residential Treatment Medicaid Billable Service (When Furnished in a Facility that Does Not Exceed 16 Beds and is Not an Institution for Mental Diseases [IMD]) (Room and Board is Not Included)

Level III.7 Medically Monitored Intensive Inpatient Treatment

NC Modified ASAM Patient Placement Criteria

Examples: McLeod, Swain, Hope Valley, ARCA.

Service Definition and Required Components

Medically Monitored Community Residential Treatment is a non-hospital twenty-four hour rehabilitation facility for adults, with twenty-four hour a day medical/nursing monitoring, where a planned program of professionally directed evaluation, care and treatment for the restoration of functioning for persons with alcohol and other drug problems and/or addiction occurs.

A service order for MMCRT must be completed by a physician, licensed psychologist, physician's assistant or nurse practitioner according to their scope of practice prior to or on the day that the services are to be provided.

Provider Requirements

MMCRT must be delivered by practitioners employed by a substance abuse provider organization that meet the provider qualification policies, procedures, and standards established by DMH and the requirements of 10A NCAC 27G These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrate that they meet these standards by being endorsed by LME. Within three years of enrollment as a provider, the organization must have achieved national accreditation. The organization must be established as a legally recognized entity in the United States and qualified/registered to do business as a corporate entity in the State of North Carolina.

Organizations that provide NMCRT must provide "first responder" crisis response on a 24/7/365 basis to the recipients who are receiving this service.

Staffing Requirements

Medically Monitored Community Residential Treatment is staffed by physicians who are available 24 hours a day by telephone and who conduct assessments within 24 hours of admission. A registered nurse is available to conduct a nursing assessment on admission and oversee the monitoring of a patient's progress and medication administration on an hourly basis. Persons who meet the requirements specified for CCS, CCAS, and CSAC under Article 5C may deliver MMCRT. The program must be under the clinical supervision of a CCAS or CCS who is on site a minimum of 8 hours per day when the service is in operation and available by phone 24 hours a day. Services may also be provided by staff who meet the requirements specified for QP or AP status in Substance Abuse according to 10A NCAC 27G.0104, under the supervision of a CCAS or CCS. Paraprofessional level providers who meet the requirements for Paraprofessional status according to 10A NCAC 27G.0104 and who have the knowledge, skills and abilities required by the population and age to be served may deliver MMCRT, under the supervision of a CCAS or CCS. Paraprofessional level providers may not provide services in lieu of no-site service provision to recipients by a qualified professional, CCS, CCAS or CSAC.

Service Type/Setting

Facility licensed under 10A NCAC 27G.3400.

Program Requirements

See Service Definition and Required Components.

Utilization Management

Authorization by the statewide vendor or the DHHS approved LME contracted with the Medicaid agency is required. The amount and duration of the service must be included in the individual's authorized Person Centered Plan. The initial authorization shall be no more than 14 days. In exceptional circumstances, up to an additional 7 days may be authorized following utilization review documented in the Person Centered Plan and service record. An example of such circumstances includes accomplishing an effective transition to another level of care. This is a short-term service that cannot exceed more than 30 days in a 12 month period.

Entrance Criteria

The recipient is eligible for this service when:

A. There is an Axis I diagnosis of a substance abuse disorder

AND

B. Level of Care Criteria Level III.7 NC Modified ASAM

Continued Stay Criteria

The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the recipient's Person Centered Plan or the recipient continues to be at risk for relapse based on history or the tenuous nature of the functional gains or any one of the following apply:

- Recipient has achieved positive life outcomes that supports stable and ongoing recovery and services need to be continued to meet additional goals.
- Recipient is making satisfactory progress toward meeting goals.
- Recipient is making some progress, but the Person Centered Plan (specific interventions) needs to be modified so that greater gains, which are consistent with the recipient's premorbid level of functioning, are possible or can be achieved.
- Recipient is not making progress; the Person Centered Plan must be modified to identify more effective interventions.
- Recipient is regressing; the Person Centered Plan must be modified to identify more effective interventions.

AND

Utilization review must be conducted within 14 days and is so documented in the Person Centered Plan and the service record.

Discharge Criteria

Recipient's level of functioning has improved with respect to the goals outlined in the Person Centered Plan, inclusive of a transition plan to step down, or no longer benefits, or has the ability to function at this level of care and any of the following apply:

1. Recipient has achieved positive life outcomes that support stable and ongoing recovery.
2. Recipient is not making progress, or is regressing and all realistic treatment options have been exhausted indicating a need for more intensive services.
3. Recipient no longer wishes to receive MMCRT services. (Note that although a recipient may no longer wish to receive MMCRT services, the recipient must still be provided with discharge recommendations that are intended to help the recipient meet expected outcomes).

Expected Outcomes

The expected outcome is abstinence. Secondary outcomes (i.e., in *abstinent* patients) include: sustained improvement in health and psychosocial functioning, reduction in any psychiatric symptoms (if present), reduction in public health and/or safety concerns, and a reduction in the risk of relapse as evidenced by improvement in empirically-supported modifiable relapse risk factors.

Upon successful completion of the treatment plan there will be successful linkage to the community of the recipient's choice for ongoing step down or support services.

Documentation Requirements

Minimum standard is a daily full service note that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, describes the provider's interventions, the time spent performing the intervention, the effectiveness of interventions, and the signature and credentials of the staff providing the service. A discharge plan shall be discussed with the client and included in the record.

Service Exclusions/Limitations

This service cannot be billed the same day as any other MH/SA service except CST or ACTT.

Note: For recipients under the age of 21, additional products, services, or procedures may be requested even if they do not appear in the N.C. State Plan or when coverage is limited to those over 21 years of age. Service limitations on scope, amount, or frequency described in the coverage policy may not apply if the product, service, or procedure is medically necessary.

Substance Abuse Halfway House
Not a Medicaid Billable Service

Level III.1 Clinically Managed Low-Intensity Residential Treatment

NC Modified ASAM Patient Placement Criteria

Service Definition and Required Components

Clinically managed low intensity residential services are provided in a 24 hour facility where the primary purpose of these services is the rehabilitation of individuals who have a substance abuse disorder and who require supervision when in the residence. The consumers attend work, school, and SA treatment services. 10A NCAC 27G.5600 sets forth required service components.

Rehab Services components offered within this level of care must include the following:
1. Disease management
2. Vocational, educational, or employment training.
3. Support services for early recovery and relapse prevention
4. Linkage with the self-help and other community resources for support (e.g. 12-step meetings, faith-based programs, etc.)

A service order for substance abuse Halfway House must be completed by a physician, licensed psychologist, physician's assistant or nurse practitioner according to their scope of practice prior to or on the day that the services are to be provided.

Provider Requirements

Halfway House must be delivered by practitioners employed by a substance abuse provider organization that meet the provider qualification policies, procedures, and standards established by DMH and the requirements of 10A NCAC 27G. These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrate that they meet these standards by being endorsed by LME. Within three years of enrollment as a provider, the organization must have achieved national accreditation. The organization must be established as a legally recognized entity in the United States and qualified/registered to do business as a corporate entity in the State of North Carolina.

Staffing Requirements

Staff requirements specified in licensure rule 10A NCAC 27G.5600.

Service Type/Setting

Facility licensed under 10A NCAC 27G.5600.

Program Requirements

See Service Definition and Required Components and licensure requirements.

Utilization Management

Authorization by the LME is required. The amount and duration of this service must be included in an authorized individual's Person Centered Plan. Initial authorization for services will not exceed 180 days.

Entrance Criteria

The recipient is eligible for this service when:
A. There is an Axis I substance abuse disorder present;
AND
B. Level of Care Criteria, level III.1 OR level III.3 NC Modified A/ASAM

Continued Stay Criteria

The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the recipient's Person Centered Plan or the recipient continues to be at risk for relapse based on history or the tenuous nature of the functional gains or any one of the following apply:

- Recipient has achieved initial Person Centered Plan goals and additional goals are indicated.
- Recipient is making satisfactory progress toward meeting goals.
- Recipient is making some progress, but the Person Centered Plan (specific interventions) needs to be modified so that greater gains, which are consistent with the recipient's premorbid level of functioning, are possible or can be achieved.
- Recipient is not making progress; the person centered plan must be modified to identify more effective interventions.
- Recipient is regressing; the Person Centered Plan must be modified to identify more effective interventions.

AND

Utilization review must be conducted every 90 days and is so documented in the Person Centered Plan and the service record.

Discharge Criteria

Recipient's level of functioning has improved with respect to the goals outlined in the Person Centered Plan, inclusive of a transition plan to step down, or no longer benefits, or has the ability to function at this level of care and any of the following apply:

1. Recipient has achieved positive life outcomes that support stable and ongoing recovery.
2. Recipient is not making progress, or is regressing and all realistic treatment options have been exhausted indicating a need for more intensive services.
3. Recipient/family no longer wishes to receive Halfway House services.

Expected Outcomes

The expected outcome of Halfway House is abstinence. Secondary outcomes (i.e., in *abstinent* patients) include: sustained improvement in health and psychosocial functioning, reduction in any psychiatric symptoms (if present), reduction in public health and/or safety concerns, and a reduction in the risk of relapse as evidenced by improvement in empirically-supported modifiable relapse risk factors.

Documentation Requirements

Minimum standard is a daily full service note for each day of Halfway House that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, describes the provider's interventions, the time spent performing the intervention, the effectiveness of interventions, and the signature and credentials of the staff providing the service. A documented discharge plan discussed with the recipient is included in the record.

Service Exclusions/Limitations

Halfway House may not be billed the same day as any other Residential Treatment or Inpatient Hospital service.

DETOXIFICATION SERVICES

Ambulatory Detoxification
Medicaid Billable Service

Level I-D Ambulatory Detoxification Without Extended On-Site Monitoring

NC Modified ASAM Patient Placement Criteria

Service Definition and Required Components

Ambulatory Detoxification Without Extended On Site Monitoring (Outpatient Detox) is an organized outpatient service delivered by trained clinicians who provide medically supervised evaluation, detoxification and referral services according to a predetermined schedule. Such services are provided in regularly scheduled sessions. The services are designed to treat the patient's level of clinical severity and to achieve safe and comfortable withdrawal from mood-altering drugs (including alcohol) and to effectively facilitate the patient's transition into ongoing treatment and recovery.

A service order for Ambulatory Detoxification Without Extended On Site Monitoring must be completed by a physician, licensed psychologist, physician's assistant or nurse practitioner according to their scope of practice prior to or on the day that the services are to be provided.

Provider Requirements

Ambulatory Detoxification Without Extended On Site Monitoring must be delivered by practitioners employed by a substance abuse provider that meet the provider qualification policies, procedures, and standards established by DMH and the requirements of 10A NCAC 27G These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Within three years of enrollment as a provider, the organization must have achieved national accreditation. The organization must be established as a legally recognized entity in the United States and qualified/registered to do business in the State of North Carolina.

Staffing Requirements

Ambulatory Detoxification Without Extended On Site Monitoring are staffed by physicians, who are available 24 hours a day by telephone and who conduct an assessment within 24 hours of admission. A registered nurse is available to conduct a nursing assessment on admission and oversee the monitoring of a patient's progress and medication. Appropriately licensed and credentialed staff are available to administer medications in accordance with physician orders and the services of counselors are available. Services must be provided by staff who meet the requirements specified for QP or AP status for Substance Abuse according to 10A NCAC 27G.0104, under the supervision of a CCAS or CCS.

Service Type/Setting

Facility licensed under 10A NCAC 27G.3300.

Entrance Criteria

A. There is an Axis I diagnosis of substance abuse disorder present

AND

B. ASAM Level of Care Criteria Level I-D (NC criteria)

Utilization Management

Authorization by the statewide vendor or the LME if approved by DHHS is required. This service must be included in an individual's Person Centered Plan. Initial authorization is limited to seven days. There is a ten day maximum.

If it is a Medicaid covered service, utilization management will be done by the state vendor or the DHHS approved LME contracted with the Medicaid agency. If it is a non-covered Medicaid service or non-Medicaid client, then the utilization review will be done by the LME.

Continued Stay/Discharge Criteria

The patient continues in Ambulatory Detoxification Without Extended On Site Monitoring until:

1 withdrawal signs and symptoms are sufficiently resolved such that he or she can participate in self-directed recovery or ongoing treatment without the need for further medical or nursing detoxification monitoring; or

2 the signs or symptoms of withdrawal have failed to respond to treatment and have intensified such that transfer to a more intensive level of detoxification service is indicated.

Expected Outcomes

The expected outcome is abstinence and reduction in any psychiatric symptoms (if present).

Documentation Requirements

Minimum standard is a daily full service note for each day of Ambulatory Detoxification Without Extended On Site Monitoring that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, describes the provider's interventions, the time spent performing the intervention, the effectiveness of interventions, and the signature and credentials of the staff providing the service. Detoxification rating scale tables e.g., Clinical Institute Withdrawal Assessment-Alcohol, Revised (CIWA-AR) and flow sheets (which include tabulation of vital signs) are used as needed, and a discharge plan which has been discussed with the recipient is also documented prior to discharge.

Service Exclusions

Cannot be billed the same day as any other service except for SA Comprehensive Outpatient Treatment and CS.

Note: For recipients under the age of 21, additional products, services, or procedures may be requested even if they do not appear in the N.C. State Plan or when coverage is limited to those over 21 years of age. Service limitations on scope, amount, or frequency described in the coverage policy may not apply if the product, service, or procedure is medically necessary.

Social Setting Detoxification
Not a Medicaid Billable Service

Level III.2-D Clinically Managed Residential Detoxification

NC Modified ASAM Patient Placement Criteria

Service Definition and Required Components

Clinically Managed Residential Detoxification is an organized service that is delivered by appropriately trained staff, who provide 24-hour supervision, observation and support for patients who are intoxicated or experiencing withdrawal symptoms sufficiently severe to require 24-hour structure and support. The service is characterized by its emphasis on peer and social support. Established clinical protocols are followed by staff to identify patients who are in need of medical services beyond the capacity of the facility and to transfer such patients to the appropriate levels of care.

A service order for Social Setting Detoxification must be completed by a physician, licensed psychologist, physician's assistant or nurse practitioner according to their scope of practice prior to or on the day that the services are to be provided.

Provider Requirements

Social Setting Detoxification must be delivered by practitioners employed by a substance abuse provider organization that meet the provider qualification policies, ~~and~~ procedures, and standards established by DMH and the requirements of 10A NCAC 27G These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrate that they meet these standards by being endorsed by LME. Within three years of enrollment as a provider, the organization must have achieved national accreditation. The organization must be established as a legally recognized entity in the United States and qualified/registered to do business as a corporate entity in the State of North Carolina.

Staffing Requirements

Persons who meet the requirements specified for CCS, CCAS, and CSAC under Article 5C may deliver Social Setting Detoxification. The program must be under the clinical supervision of a CCS or CCAS who is available 24 hours a day by telephone. All clinicians who assess and treat patients are able to obtain and interpret information regarding the needs of the patients including the signs and symptoms of alcohol and other drug intoxication and withdrawal as well as the appropriate treatment and monitoring of those conditions and how to facilitate entry into ongoing care. Back-up physician services are available by telephone 24 hours a day. Services must be provided by staff who meet the requirements specified for QP or AP status in Substance Abuse according to 10A NCAC 27G.0104, under the supervision of a CCAS or CCS. Paraprofessional level providers who meet the requirements for Paraprofessional status according to 10A NCAC 27G.0104 and Certified Peer Support Specialist and who have the knowledge, skills and abilities required by the population and age to be served may deliver Social Setting Detoxification, under the supervision of a CCAS or CCS. Paraprofessional level providers may not provide services in lieu of on-site service provision to recipients by a qualified professional, CCS, CCAS or CSAC.

Service Type/Setting

Facility licensed under 10A NCAC 14V.3200.

Entrance Criteria

A. There is an Axis I diagnosis of substance abuse disorder present

AND

B. ASAM Level of Care Criteria Level III.2-D (NC criteria)

Utilization Management

Authorization by the LME is required. This service must be included in an individual's Person Centered Plan. Initial authorization is limited to seven days.

Continued Stay/Discharge Criteria

The patient continues in Social Setting Detoxification until:

1. withdrawal signs and symptoms are sufficiently resolved that he or she can be safely managed at a less intensive level of care; or
2. the signs or symptoms of withdrawal have failed to respond to treatment and have intensified such that transfer to a more intensive level of detoxification service is indicated.

Expected Outcomes

The expected outcome of this service is abstinence and reduction in any psychiatric symptoms (if present).

Documentation Requirements

Minimum standard is a shift note for every 8 hours of service provided that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, describes the provider's interventions, the time spent performing the intervention, the effectiveness of interventions and the signature of the staff providing the service. In addition, detoxification rating scale tables (e.g., Clinical Institute Withdrawal Assessment-Alcohol, Revised (CIWA-AR) and flow sheets (which include tabulation of vital signs) are used as needed. A documented discharge plan discussed with the recipient is included in the record.

Service Exclusions

This service cannot be billed the same day as any other MH/SA service except CS, CST, and ACTT.

Non-Hospital Medical Detoxification
Medicaid Billable Service

Level III.7-D Medically Monitored Inpatient Detoxification

NC Modified ASAM Patient Placement Criteria

Service Definition and Required Components

Medically Monitored Detoxification is an organized service delivered by medical and nursing professionals, that provides for 24-hour medically supervised evaluation and withdrawal management in a permanent facility affiliated with a hospital or in a freestanding facility of 16 beds or less. Services are delivered under a defined set of physician-approved policies and physician-monitored procedures and clinical protocols.

A service order for Medically Monitored Detoxification must be completed by a physician, licensed psychologist, physician's assistant or nurse practitioner according to their scope of practice prior to or on the day that the services are to be provided.

Provider Requirements

Medically Monitored Detoxification must be delivered by practitioners employed by a substance abuse provider organization that meet the provider qualification policies and procedures established by DMH and the requirements of 10A NCAC 27I.0208 (Endorsement of Providers). These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrate that they meet these standards by being endorsed by LME. Within three years of enrollment as a provider, the organization must have achieved national accreditation. The organization must be established as a legally recognized entity in the United States and qualified/registered to do business as a corporate entity in the State of North Carolina.

Staffing Requirements

Medically Monitored Detoxification are staffed by physicians, who are available 24 hours a day by telephone and who conducts an assessment within 24 hours of admission. A registered nurse is available to conduct a nursing assessment on admission and oversee the monitoring of a patient's progress and medication administration. The level of nursing care is appropriate to the severity of patient needs based on the clinical protocols of the program. Appropriately licensed and credentialed staff are available to administer medications in accordance with physician orders. Persons who meet the requirements specified for CCS, CCAS, and CSAC under Article 5C may deliver a planned regimen of 24-hour evaluation, care and treatment services for patients engaged in Medically Monitored Detoxification. The planned regimen of 24-hour evaluation, care and treatment services must be under the clinical supervision of a CCS or CCAS who is available by phone 24 hours a day. The planned regimen of 24-hour evaluation, care and treatment services for patients engaged in Medically Monitored Detoxification must be provided by staff who meet the requirements specified for QP or AP status in Substance Abuse according to 10A NCAC 27G.0104, under the supervision of a CCAS or CCS. Paraprofessional level providers who meet the requirements for Paraprofessional status according to 10A NCAC 27G.0104 and who have the knowledge, skills and abilities required by the population and age to be served may deliver the planned regimen of 24-hour evaluation, care and treatment services for patients engaged in Medically Monitored Detoxification, under the supervision of a CCAS or CCS. Paraprofessional level providers may not provide services in lieu of on-site service provision to recipients by a qualified professional, CCS, CCAS or CSAC.

Service Type/Setting

Facility licensed under 10A NCAC 27G.3100.

Entrance Criteria

A. There is an Axis I diagnosis of substance abuse disorder present

AND

B. ASAM Level of Care Criteria Level III.7-D (NC criteria)

Utilization Management

Authorization by the statewide vendor or the DHHS approved LME contracted with the Medicaid Agency is required. This service must be included in an individual's Person Centered Plan. Initial authorization is limited to seven days.

If it is a Medicaid covered service, utilization management will be done by the state vendor or the DHHS approved LME contracted with the Medicaid agency. If it is a non-covered Medicaid service or non-Medicaid client, then the utilization review will be done by the LME.

Continued Stay/Discharge Criteria

The patient continues in Medically Monitored Detoxification until:

1. withdrawal signs and symptoms are sufficiently resolved that he or she can be safely managed at a less intensive level of care; or
2. the signs or symptoms of withdrawal have failed to respond to treatment and have intensified such that transfer to a more intensive level of detoxification service is indicated.

Expected Outcomes

The expected outcome of this service is abstinence and reduction in any psychiatric symptoms if present.

Documentation Requirements

Minimum standard is a full daily note that includes number, date of service, purpose of contact, describes the provider's interventions, the time spent performing the intervention, the effectiveness of interventions, and the signature and credentials of the staff providing the service. Detoxification rating scale tables [e.g., Clinical Institute Withdrawal Assessment-Alcohol, Revised (CIWA-AR)] and flow sheets (includes tabulation of vital signs) are used as needed. A discharge plan, which has been discussed with the recipient, is also included in the record.

Service Exclusions

This service cannot be billed the same day as any other MH/SA service except CS, CST, and ACTT. This is a short-term service that cannot be billed for more than 30 days in a short-term period.

Note: For recipients under the age of 21, additional products, services, or procedures may be requested even if they do not appear in the N.C. State Plan or when coverage is limited to those over 21 years of age. Service limitations on scope, amount, or frequency described in the coverage policy may not apply if the product, service, or procedure is medically necessary.

Medically Supervised or ADATC Detoxification/Crisis Stabilization Medicaid Billable Service (When Furnished to Adults in Facilities with Fewer than 16 Beds)

LEVEL III.9-D Medically Supervised Detoxification/Crisis Stabilization

NC Modified ASAM Patient Placement Criteria

Service Definition and Required Components

Medically Supervised or ADATC Detoxification/Crisis Stabilization is an organized service delivered by medical and nursing professionals that provides for 24-hour medically supervised evaluation and withdrawal management in a permanent facility with inpatient beds. Services are delivered under a defined set of physician-approved policies and physician-monitored procedures and clinical protocols. Recipients are often in crisis due to co-occurring severe substance-related mental disorders, such as an acutely suicidal patient, or persons with severe mental health problems that co-occur with more stabilized substance dependence who are in need short term intensive evaluation, treatment intervention, or behavioral management to stabilize the acute or crisis situation. The service has restraint and seclusion capabilities. Established clinical protocols are followed by staff to identify patients with severe biomedical conditions who are in need of medical services beyond the capacity of the facility and to transfer such patients to the appropriate level of care.

A service order for Medically Supervised or ADATC Detoxification/Crisis Stabilization must be completed by a physician, licensed psychologist, physician's assistant or nurse practitioner according to their scope of practice prior to or on the day that the services are to be provided.

Provider Requirements

Medically Supervised or ADATC Detoxification/Crisis Stabilization must be delivered by practitioners employed by a substance abuse provider organization that meet the provider qualification policies, procedures, and standards established by DMH and the requirements of 10A NCAC 27G These policies and procedures set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Provider organizations must demonstrate that they meet these standards by being endorsed by LME. Within three years of enrollment as a provider, the organization must have achieved national accreditation. The organization must be established as a legally recognized entity in the United States and qualified/registered to do business as a corporate entity in the State of North Carolina.

Staffing Requirements

Medically Supervised or ADATC Detoxification/Crisis Stabilization are staffed by physicians and psychiatrists, who are available 24 hours a day by telephone and who conduct assessments within 24 hours of admission. A registered nurse is available to conduct a nursing assessment on admission and oversee the monitoring of a patient's progress and medication administration on an hourly basis. Appropriately licensed and credentialed staff are available to administer medications in accordance with physician orders. Persons who meet the requirements specified for CCS, CCAS, and CSAC under Article 5C may deliver a planned regimen of 24-hour evaluation, care and treatment services for patients engaged in Medically Supervised or ADATC Detoxification/Crisis Stabilization. The planned regimen of 24-hour evaluation, care and treatment services must be under the clinical supervision of a CCS or CCAS who is who is available by phone 24 hours a day. The planned regimen of 24-hour evaluation, care and treatment services for patients engaged in Medically Supervised or ADATC Detoxification/Crisis Stabilization must be provided by staff who meet the requirements specified for QP or AP status for Substance Abuse according to 10A NCAC 27G.0104, under the supervision of a CCAS or CCS.

Paraprofessional level providers who meet the requirements for Paraprofessional status according to 10A NCAC 27G.0104 and who have the knowledge, skills and abilities required by the population and age to be served may deliver the planned regimen of 24-hour evaluation, care and treatment services for patients engaged in ADATC Detoxification/Crisis Stabilization, under the supervision of a CCAS or CCS.

Service Type/Setting

(Licensure TBD)

Entrance Criteria

A. There is an Axis I diagnosis of substance abuse disorder present

AND

B. ASAM Level of Care Criteria Level III.9-D (NC criteria)

Utilization Management

Authorization by the statewide vendor or the LME is required. This service must be included in an individual's Person Centered Plan. Initial authorization is limited to 5 days.

If it is a Medicaid covered service, utilization management will be done by the state vendor or the DHHS approved LME contracted with the Medicaid agency. If it is a non-covered Medicaid service or non-Medicaid client, then the utilization review will be done by the LME.

Continued Stay/Discharge Criteria

The patient continues in Medically Supervised or ADATC Detoxification/Crisis Stabilization until:

1. withdrawal signs and symptoms are sufficiently resolved that he or she can be safely managed at a less intensive level of care; or
2. the signs or symptoms of withdrawal have failed to respond to treatment and have intensified such that transfer to a more intensive level of detoxification service is indicated; or
3. the addition of other clinical services are indicated.

Expected Outcomes

The expected outcome of this service is abstinence and reduction in any psychiatric symptoms (if present).

Documentation Requirements

Minimum standard is a daily full service note that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, describes the provider's interventions, the time spent performing the intervention, the effectiveness of interventions, and the signature and credentials of the staff providing the service. In addition, detoxification rating scale tables [e.g., Clinical Institute Withdrawal Assessment-Alcohol, Revised (CIWA-AR)] and flow sheets (includes tabulation of vital signs) are used as needed. A discharge plan, which has been discussed with the recipient, is also included in the record.

Service Exclusions

This service cannot be billed the same day as any other MH/SA service except CS, CST, and ACTT.
This is a short-term service that cannot be billed for more than 30 days in a 12-month period.